IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

DANIEL LOVELACE and HELEN LOVELACE,
Individually and as Parents of
BRETT LOVELACE, Deceased

Plaintiffs,

vs. **No. 2:13-cv-02289-SHL-dkv**

PEDIATRIC ANESTHESIOLOGISTS, P.A.;
BABU RAO PAIDPAILLI; and
MARK P. CLEMONS,

Defendants.

DEFENDANT MARK P. CLEMONS, M.D.'S MOTION TO JOIN DEFENDANTS', PEDIATRIAC ANESTHESIOLOGISTS, P.A., AND BABU RAO PAIDIPALLI, M.D.'S MOTION TO EXCLUDE OPINIONS OF PLAINTIFF'S DESIGNATED EXPERT WITNESSES JASON KENNEDY, M.D. AND ROBERT E. MARSH UNDER F.R.E. 702/*DAUBERT* AND MEMORANDUM OF LAW IN SUPPORT OF MOTION

Comes now defendant, Dr. Mark P. Clemons, and moves the Court to exclude opinions of plaintiff's designated expert witnesses Jason Kennedy, M.D., and Robert E. Marsh, under F.R.E. 702/*Daubert*. In support of this Motion, Dr. Clemons relies upon Federal Rule of Evidence 702/*Daubert* and would adopt and incorporate by reference the Motion and Memorandum of Law filed by co-defendants, Pediatric Anesthesiologists, P.A., and Babu Rao Paidipalli, M.D.'s filed in this Court on August 9, 2014 and attached hereto as Exhibit A.

LEWIS THOMASON

By: s/ Marcy D. Magee
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been properly served upon all counsel of record identified below via U.S. Mail, first class postage prepaid, and via the Court's ECF filing system:

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This the 12 day of August, 2014.

s/ Marcy D. Magee
Marcy D. Magee

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESESEE

DANIEL LOVELACE and
HELEN LOVELACE, Individually, and as Parents of
BRETT LOVELACE, deceased,

Plaintiffs,

Vs.

No. 2:13-cv-02289 dkv
JURY TRIAL DEMANDED

PEDIATRIC ANESTHESIOLOGISTS, P.A.;
BABU RAO PAIDIPALLI; and
MARK P. CLEMONS,

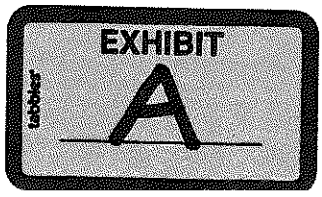
Defendants.

DEFENDANTS', PEDIATRIC ANESTHESIOLOGISTS, P.A., AND BABU RAO PAIDIPALLI, M.D.'S MOTION TO EXCLUDE OPINIONS OF PLAINTIFF'S DESIGNATED EXPERT WITNESSES JASON KENNEDY, M.D. AND ROBERT E. MARSH UNDER F.R.E 702/*DAUBERT* AND MEMORANDUM OF LAW IN SUPPORT OF MOTION

Come now the defendants, Pediatric Anesthesiologists, P.A. and Babu Rao Paidipalli, M.D., by and through counsel of record, and in support of this Motion to Exclude Experts under F.R.E 702/*Daubert* would show to the Court as follows:

BACKGROUND

This is a medical malpractice lawsuit in which plaintiffs, Daniel and Helen Lovelace, assert a claim for medical malpractice against Pediatric Anesthesiologists, P.A., Babu Rao Paidipalli, M.D., (a pediatric anesthesiologist) and Mark D. Clemons, M.D. (an otolaryngologist), and also assert a claim against these defendants for negligent infliction of emotional distress based upon alleged medical malpractice in the care provided to plaintiffs' twelve year old son, Brett Lovelace, at Methodist Le Bonheur Children's Medical Center,



following a tonsillectomy/adenoidectomy surgery on March 12, 2012, allegedly resulting in Brett Lovelace's death on March 14, 2012. (ECF 1, paragraphs 8 – 12.) Defendants deny any medical negligence on their part and deny that they caused injury to, and the subsequent death of the patient, Brett Lovelace. (ECF 13, paragraph 3.) Plaintiffs settled with Methodist LeBonheur pre-suit based upon the egregious care rendered by a nurse in the recovery room, which included fraudulent documentation of the child's vital signs and playing on Facebook and another website while charged with monitoring the child. The nurse's license was later revoked as a result of her actions.

Plaintiffs designated their only standard of care expert, Jason Kennedy, M.D., an adult cardiovascular anesthesiologist, on April 9, 2014. Dr. Kennedy's discovery deposition was taken by the defendants on June 25, 2014. Plaintiff also disclosed a damages expert, Robert E. Marsh, CPA. Mr. Marsh's discovery deposition was taken by the defendants on June 9, 2014.

In accordance with the "Order Granting Defendants' Unopposed Motion for Extension of Discovery Deadlines First Amended Scheduling Order" entered in the cause on January 22, 2014, (ECF 89), Motions to Exclude Experts under F.R.E. 702/Daubert Motions shall be filed by August 9, 2014. Defendants now therefore move to exclude opinions of Plaintiffs' experts, Jason Kennedy, M.D. and Robert E. Marsh, CPA, on the grounds that their opinions are unreliable under the case of *Daubert v. Merrill Dow Pharmaceuticals*, 509 U.S. 579, 113 S. Ct. 286 (1993) and Rule 702 of the Federal Rules of Evidence. Defendants seek exclusion because their opinions are outside of their respective areas of expertise, offer opinions that lack reliability under any stated methodology, lack peer-review support, demonstrate no established rate of error, which opinions are also not shown to be generally accepted in the relevant medical community and are "for this litigation" and thus deficient. Because these opinions are lacking in

trustworthiness pursuant to Rule 703 of the Federal Rules of Evidence, Defendants contend that the opinions set forth below should be excluded from the trial of this case.

In support of excluding testimony of Plaintiffs' experts under *Daubert*, defendant relies upon the sworn deposition testimony of Dr. Kennedy and Mr. Marsh, excerpts of which are attached as an exhibit to this Motion.

ARGUMENT

As gatekeeper, the Court must ensure that a witness has the requisite ability to give expert testimony. *Daubert v. Merrill Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993). In *Daubert*, the Court determined that Rule 702 of the Federal Rules of Evidence allotted to the trial judge the task of determining whether an expert's testimony is admissible. Daubert, 509 U.S. at 597, 113 S.Ct. at 2799. The Court held that "general acceptance" was not indicative of the admissibility of scientific evidence. *Id.* The Court also noted that with determining whether expert testimony is admissible, the trial judge must determine that the testimony "rests on a reliable foundation and is relevant to the task at hand." *Id.*

The United States Supreme Court expanded its analysis of the admissibility of scientific evidence in *General Electric Company v. Joiner*, 522 U.S. 136, 118 S.Ct. 512 (1997). The Court noted:

> [N]othing in either Daubert or the Federal Rules of Evidence requires a district court to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert. A court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.

Joiner, 522 U.S. at 146, 118 S.Ct. 519. The Court thus held that a district court's decision to admit or exclude scientific evidence would be measured by the abuse of discretion standard. Id. Hence, it is within a trial or district court's discretion to conclude that expert testimony is inadmissible.

In *Kumho Tire Company, Ltd. v. Carmichael*, the United States Supreme Court expanded the trial court's duty to measure all expert testimony for reliability and relevance. 526 U.S. 137, 119 S.Ct.1167 (1999). The Court disagreed with the Eleventh Circuit's holding that *Daubert* factors may only be considered when an "expert 'relies on the application of scientific principles' but not where an expert relies 'on skill- or experience-based observations.'" *Kumho*, 526 U.S. at 151, 119 S.Ct. at 1176. The Court responded by writing, "[w]e do not believe that Rule 702 creates a schematism that segregates expertise by type while mapping certain kinds of questions to certain kinds of experts. Life and the legal cases that it generates are too complex to warrant so definitive a match." *Id.* The Court stated that the trial judge must have a great amount of discretion in determining whether an expert's testimony is reliable. *Id.* at 151, 1176. Hence, if the trial or district court has doubts as to the admissibility of evidence, as long as these doubts are reasonable, there is no abuse of discretion. *Id.* at 153, 1177.

In a medical malpractice case, the plaintiff must prove by expert testimony: 1) the standard of care in the defendant's specialty; 2) a deviation from the standard; 3) and an injury caused by the deviation. Tenn. Code Ann. § 29-26-115. Medical malpractice cases typically involve a dispute over the diagnosis, treatment or other scientific matters. *Peete v. Shelby County Health Care Corp.*, 938 S.W.2d 693 (Tenn. Ct. App. 1996). Thus, expert testimony is required.

Rule 702 of the Federal Rules of Evidence was amended in response to *Daubert* and the many cases that followed, and provides that a qualified expert may testify in the form of an opinion or otherwise if:

> (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;
> (b) the testimony is based on sufficient facts or data;
> (c) the testimony is the product of reliable principles and methods; and
> (d) the expert has reliably applied the principles and methods to the fact of the case;

Fed. R. Evid. 702.

Rule 703 of the Federal Rules of Evidence states if the facts or data relied upon by the expert would otherwise be inadmissible; the proponent of the opinion may disclose them to the jury only if their probative value in helping the jury evaluate the opinion substantially outweighs their prejudicial effect. Fed. R. Evid. 703

Basis for Exclusion of Opinions of Dr. Kennedy:

Defendant avers that certain opinions of Dr. Kennedy should be excluded at trial under Rule 702 of the Federal Rules of Evidence. Dr. Kennedy is not a pediatric anesthesiologist like Dr. Paidipalli. He admits in his deposition that he does not put children to sleep, or wake them up, and thus he had adopted positions and opinions that are for this litigation only and are thus deficient under *Daubert.*

Dr. Kennedy is an adult cardiac anesthesiologist in Nashville. He takes care of "adult patients undergoing cardiac anesthesia and adult patients undergoing critical care." He also takes care of adult patients in the ICU. Dr. Kennedy has only been a licensed practicing anesthesiologist since June 2010-less than two years prior to the date in question, March 18, 2012. (See Expert Witness Report of Jason Kennedy, Exhibit 1). He does "not work in the department of pediatric anesthesiology." (See Deposition of Jason Kennedy, Exhibit 2, P. 8, l. 11-20.) He does not take care of pediatric patients like 12 year old Brett Lovelace who have

surgery. His practice concerns adults with cardiac problems-not children that have had throat surgery.

He is not certified as a pediatric anesthesiologist by any organization. (See Curriculum Vitae of Jason Kennedy, Exhibit 3.) Dr. Kennedy has no specialized training in pediatric anesthesiology. (See Exhibit 2, p. 25 l. 8-12). In fact, he has no interest in pediatric anesthesiology. (See Exhibit 2, p. 27 l. 22-25)

Dr. Kennedy's opinions, therefore, were developed for the purposes of this litigation. He had to research textbooks to develop his opinions of the standard of care for Dr. Paidipalli. While Dr. Kennedy asserts that he reviewed Miller's Anesthesia generally, and "two or three pediatric-specific textbooks" to formulate his opinions in the case, he could not and did not even identify with any specificity the title, chapters, authors, or studies to which he referred. He admitted that these texts themselves were not authoritative on the issues of the pediatric anesthesiology rendered in this case. P.12, l. 12-p.13 l. 23. Dr. Kennedy cites three sources in his expert report that he apparently had to rely upon to determine what the standard of care was in the case to drfat his report since he has no experience with children like Brett Lovelace. (See Exhibit 1, fn. 2-3.)

He conducted no testing relative to his opinions in this case. (See Exhibit 1). He has given no lectures or presentations specific to pediatric anesthesiology. (See Exhibit 2, P. 32, l. 24-25). He has not authored any peer reviewed study or paper. (See Exhibit 3.) Dr. Kennedy has not authored any articles or studies, whatsoever, on pediatric anesthesiology or post surgical complications involving children or throat surgery. (See Exhibit 3). In fact, his only publication as an anesthesiologist was in a text and concerns "intraoperative monitoring of patients' cardiac function in during cardiopulmonary bypass." (See Exhibit 2, p. 10, l. 10-13). This case involves a tonsillectomy/adenoidectomy in a 12 year old child-not an adult cardiac patient.

Dr. Kennedy has never been qualified as an expert witness before. This is his first case to attempt to testify as an expert witness in any court. (See Exhibit 2, p. 40, l. 12-20.)

As seen from his complete lack of training and experience with this type of patient and surgery, his testimony would not assist the trier of fact as required and should be excluded. He has developed opinions solely for the purposes of this litigation.

Basis for Exclusion of Opinions of Robert Marsh, CPA:

Defendants aver that Mr. Marsh must be excluded as an expert for the following reason – his testimony regarding economic damages resulting from the alleged injury lacks any basis that adequately supports his conclusions – an analytical gap exists between the data and the opinion offered. Defendants are not asserting that Mr. Marsh is not an expert within the meaning of Rule 702, but his testimony should be excluded because the basis for the witness's opinion, i.e. testing, research, studies, or experience-based observations, does not adequately support the expert's conclusions. *General Electric Co. v. Joiner,* 522 U.S. 136, 118 S. Ct. 512, 139 L.Ed.2d 508 (1997). His opinions lack peer-review support, credentials and scientific basis or evidentiary support from those fields. Moreover, his opinions provide no established rate of error; and his opinions are not based upon data generally accepted by economists.

Mr. Marsh failed to properly use measurements or records from the decedent; he bases his opinions on anecdote and assumptions that not scientific or which are outside any claimed area of expertise (economist). Mr. Marsh is a professional witness who makes a living reviewing cases in litigation. His opinions are solely based upon an average white male and fails to take into account the specific information that was available to him regarding Brett's learning issues. He gives assumptions upon assumption, failing to take into consideration how this child and this child's family fit into the equation.

For instance, Mr. Marsh has asserted that the plaintiffs have suffered an economic loss as a result of the death of their son. However, all his calculations are derived from assumptions of what the future may have held for Brett Lovelace – i.e. – whether he would have even completed high school, let alone trade school or even college. Marsh's testimony reads as follows:

> **Q: And so you didn't factor in his mental or educational accomplishments, or lack therof. Is that a fair statement.**
> **A: That's correct. I treated him as the average statistical individual and provided earnings for a range of different education attainments.**

(See Deposition of Robert E. Marsh, pg. 12, lines 2-8, attached hereto as Exhibit 4.) Mr. Marsh also stated that he was aware that Brett Lovelace was home schooled but admittedly stated:

> **A: ..I'm simply not an expert on home school, and there's not a whole lot of statistics with regard to education attainment of those who are home schooled that I feel comfortable relying on it.**

(See Exhibit 4, pg. 33, lines 6-10).

Moreover, Mr. Marsh gives assumptions of potential earnings based upon the assumption that Brett would have completed high school, yet he failed to take into consideration that Brett failed kindergarten, and by the time he was in sixth grade he could only read on a second grade level. (See Exhibit 4, pg. 34, lines 6-24. Dr. Marsh admits that he could have prepared a potential earnings range in his calculations for people who have not graduated high school but didn't make such calculations in his report presumably because his potential earnings would have been lower. (See Exhibit 4 pg. 36, lines 8-11).

The trial court, as the gatekeeper of proof, must ensure that the basis for the witness's opinion adequately supports the expert's conclusions. Marsh is relying on assumptions, not fact. In the present case, there is no data that can support the opinions offered by Marsh. Moreover, the opinion evidence is connected to the existing data only by the *ipse dixit* of the expert. Marsh

admits that he has had to make numerous assumptions to arrive at his calculations that are less than certain. Mere inferences are insufficient to create a straightforward connection between the expert's knowledge and the basis for the opinion – an analytical gap exists. As such, Marsh's speculative opinions on economic loss should be excluded.

CONCLUSION

Defendants' respectfully urge the Court to grant this FRE Rule 702/*Daubert* challenge to Plaintiffs' experts, Dr. Kennedy and Mr. Marsh, and rule that they not be permitted to testify by opinion as to the matters set out above.

By: s/ W. Bradley Gilmer
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing has been served via the Court's electronic filing system upon:

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Memphis, TN 38103

this 9th day of August, 2014.

s/ W. Bradley Gilmer
W. BRADLEY GILMER

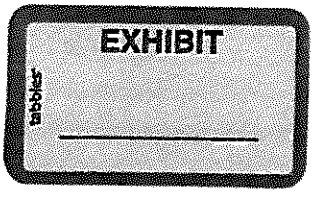
Expert Witness Report

DANIEL LOVELACE and HELEN LOVELACE, Individually, and as Parents of BRETT LOVELACE, Deceased, vs. PEDIATRIC ANESTHESIOLOGISTS, P.A.; BABU RAO PAIDIPALLI; and MARK P. CLEMONS

* * * * *

Prepared by: Jason D. Kennedy, M.D.

Prepared for: Mark Ledbetter
Halliburton and Ledbetter



I, Jason D. Kennedy, M.D., declare and state as follows:

I am over the age of 18 and have personal knowledge of the facts stated in this report.

I graduated from the University of Alabama School of Medicine in June 2003. I completed an internship at Carraway Methodist Medical Center in Birmingham, Alabama; a residency in anesthesiology from the University of Alabama at Birmingham Medical Center, Birmingham, Alabama from July 2004 through June 2007; a fellowship in Critical Care Anesthesiology from Emory University Medical Center, Atlanta, Georgia; and, a fellowship in cardio-thoracic Anesthesiology from Emory University Medical Center, Atlanta, GA. I have been a licensed medical doctor in the state of Tennessee with a specialty in Anesthesiology since June 8, 2010, and my Tennessee medical license number is 46094. My qualifications are set forth in my c.v. attached hereto.

I am currently an Assistant Professor of Clinical Anesthesiology at Vanderbilt University in Nashville, Tennessee, and have been in this position from July 2010 to present. Prior to my current position, I was an Instructor in Anesthesiology, Department of Anesthesiology, University of Alabama Birmingham-UAB (Birmingham, AL).

I have reviewed the medical records of Brett Lovelace for the hospitalization of March 12, 2012 through March 14, 2012 from LeBonheur Children's Medical Center. I have also reviewed the following:

(a) Depositions of the parties;

(b) Discovery;

(c) Photographs of Brett Lovelace at LeBonheur; and

(d) Pleadings.

I am familiar with the applicable standards of care and issues in this case specifically regarding anesthesiology treatment and care, medical, surgical and post-surgical/PACU care, in and for the Memphis area and hospital where the incident occurred,[1] and my opinions are set forth as follows:

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[1] I belong to the American Society of Anesthesiologists [ASA] and the Society of Cardiovascular Anesthesiology [SCA], both organizations with physicians practicing in Memphis, Knoxville, Chattanooga, and surrounding areas; I attend meeting[s] of the ASA and SCA where physicians, including anesthesiologists from Memphis, Nashville, Knoxville, Chattanooga and surrounding areas attend; that I have been to Memphis three or four times; that I am familiar with and have worked surgical cases with ENT physicians as well and am familiar with their standard of care in the surgical context as respects the continued need to protect the patient's airway and ventilation and with the safety practices which were not followed in this case, viz., safe positioning, airway patency, supplemental oxygen needed post-surgery and in the PACU; that the communities of Nashville, where I practice, and Memphis are of comparable size; the medical communities adhere to similar practices and rules; there are more than 15 hospitals in Nashville and Memphis; each city has a hospital reported to be among the 100 largest hospitals in

1. I have reviewed the medical records of Brett Lovelace which were provided to the attorney for the Lovelace family for the dates of hospitalization in March of 2012 from LeBonheur Children's Medical Center.

2. Defendants failed to follow the proper standard of care in that they failed to appropriately ensure that Brett was appropriately and safely monitored and assessed in the PACU. There are no records of them assessing the patient in the recovery room until after the initiation of the code, a period of about an hour. Both physicians agreed that such monitoring and assessment was necessary, but neither assured nor verified that proper positioning, proper supplemental oxygen or proper monitoring occurred or was provided.[2] Anesthesiologist supervision was needed until the patient, Brett Lovelace, was awake and maintaining his own airway.

3. Defendants failed to follow the proper standard of care in that they failed to appropriately ensure that Brett had fully emerged from and recovered appropriately from the anesthetic prior to the removal of the endotracheal tube. Brett's documented tidal volumes prior to extubation were a mere 145-180 cc's, this is a very small tidal volume for an 81 kg child. This, combined with documented hypercarbia, makes it unlikely that he was ventilating adequately at the time of extubation. Brett's high end tidal C02 level of 56 torr, as recorded on the anesthetic record, support the assertion that appropriate assessment and attention would have prevented his subsequent hypoxemia and acidosis.

4. The Defendants failed to follow standards of care in that they failed to ensure adequate ventiltory support in a patient who was obese, with sleep apnea. Brett's initial arterial blood gas (ABG) is recorded as a pH of 6.70, a partial pressure of CO2 of 96/, a partial pressure of oxygen of Pa02 502/ HC03 of 12. This ABG was performed after at least 10 minutes of positive pressure ventilation, since per the code note, he was reintubated at 1204 and the first blood gas is reported to be at 1218. Therefore, the initial C02 was likely much higher. There is a sample that is reported to be a venous sample that has a pH of 6.59, a C02 of >130. This is an incredible amount of hypercarbia resulting likely a prolonged period of hypoventilation as consistent with a patient who was extubated in a non-fully awakened state (deep extubation) and without appropriate insurance that he was maintaining adequate respiratory rate and tidal volumes. This was a clear breach of the standard of care in any patient who had undergone a general anesthetic, and especially true in an obese child with sleep-deprived breathing who undergoes tonsillectomy.

5. Defendants failed to follow the proper standard of care in that they failed to appropriately ensure that Brett had adequate oxygen supplementation in the post-anesthesia care

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America, e.g., BMH, Memphis, and VUMC, Nashville; and I have attended CME with Memphis anesthesiologists, e.g., New Horizons in Anesthesiology, and studied and learned the same principles and methods, as well as in medical school.

[2] See Clinical Practice Guideline: Tonsillectomy in Children, Baugh, et. al., Otolaryngology - Head and Neck Surgery 2011 144: S1; Guidelines for Patient Care in Anesthesiology, American Society of Anesthesiologists, October 29, 2011, Section I - III, including post-anesthetic care.

unit (PACU). Defendants failed to reaffirm airway patency and adequacy of breathing. Defendants should have continued delivery of oxygen by mask to Brett Lovelace until his recovery was complete. Further, Defendants failed to maintain airway patency with simple airway maneuvers or oro-nasopharyngeal airway until the patient was fully awake. Neither Defendant could explain these lapses, but both agreed that such steps were required and standard.

6. Defendants failed to follow the proper standard of care in that they failed to appropriately ensure that Brett was appropriately monitored in the post anesthesia care unit. A patient in the prone or knee-chest position is difficult to monitor and ensure adequate oxygenation. Dr. Paidipalli did not attend the patient in the PACU, reportedly and admittedly; and Dr. Clemons did nothing to correct Brett Lovelace's position when he saw him prone and on his face without oxygen support. Placing Brett Lovelace in a left lateral or semi-prone ("tonsil position"), slight head-down position, with a pillow under the chest to allow secretions and blood to drain, was necessary, as well known, but not done, here, which was a failure to follow the pertinent standard of care.[3]

7. The ENT surgeon failed to follow standards of care in that he failed to appropriately care for and recognize that Brett was not fully awakened from anesthesia. He also failed to appropriately intervene by his lack of any personal action in the care of Brett or by not calling for an appropriate trained anesthesiologist to ensure that Brett was oxygenating and ventilating appropriately. An ENT surgeon routinely cares for such patients and should have known to intervene at the time he saw Brett in the PACU.

8. The ENT surgeon failed to follow standards of care in that he failed to intervene in Brett's poor positioning for a patient who was at high risk of respiratory compromise. By documentation, he saw Brett in the PACU in the knee-chest prone position prior to his arrest, and did not act appropriately to correct the situation.

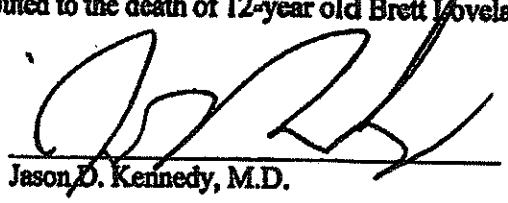
9. Neither physician appropriately followed up on the possibility of the most likely anesthetic complication and cause of death in patients undergoing T & A – bleeding or loss of airway. Neither arranged for adequate follow-up and evaluation by themselves, a CRNA or the nursing staff. The suggestion that clinical judgment is appropriate for post-anesthetic care in this case is analogous to the judgment that a pilot uses when operating an airplane; however, the judgment of a physician is also based upon instruments similar to those that provide objective information and data to a pilot. For example, in a storm, a pilot must disregard his physical senses and use the instruments to appropriately fly the airplane. By analogy, the anesthesiologist, like the pilot, has to have an objective sense of the standard physiology variables in order to "land the plane" or bring the patient safely out of anesthesia. In this case, clinical judgment is not a proper substitute for failure to pay attention to the details and condition of the patient, and to use customary and accepted safeguards.

10. Neither physician adequately observed the patient in the PACU so as to be able to exercise any judgment whatsoever. The patient was abandoned. It does not appear that either physician advised the PACU nursing staff of the risks of this particular patient. The

[3] Guidelines, Difficult Airway Society Guidelines For the Management of Tracheal Extubation,, Anesthesia 2012, 67, 318-340, Table 3.

anesthesiologist did not ensure that there was an adequate transfer of care information nor remain with the patient as long as medically necessary nor ensure that the patient was discharged from the PACU unit in accordance with proper anesthesiology policies. The ENT surgeon did no better. See fn. 2, Guidelines for Patient Care in Anesthesiology, supra, at III, E, 1-6.

The foregoing opinions are rendered to a reasonable degree of medical certainty; it is further my opinion that the lack of attention and supervision, and failure to follow the appropriate standard of care, directly caused and contributed to the death of 12-year old Brett Lovelace.



Jason D. Kennedy, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION
- - - - - -

DANIEL LOVELACE, and HELEN LOVELACE, Individually, and as Parents of BRETT LOVELACE, deceased,

Plaintiffs,

vs.

PEDIATRIC ANESTHESIOLOGISTS, P.A.; BABU RAO PAIDIPALLI; and MARK P. CLEMONS,

Defendants.

No. 2:13-cv-02289-SHL-dkv

VIDEOTAPED DEPOSITION OF:

JASON D. KENNEDY, M.D.

NASHVILLE, TENNESSEE

WEDNESDAY, JUNE 25, 2014

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FILE NO.: A80609D

A80609D
JASON D. KENNEDY, M.D. JUNE 25, 2014

IN THE UNITED STATES DISTRICT COURT
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PEDIATRIC ANESTHESIOLOGISTS, P.A.; BABU RAO PAIDIPALLI; and MARK P. CLEMONS,
Defendants.

The videotaped deposition of Jason D. Kennedy, M.D., taken on behalf of the Defendants, Pediatric Anesthesiologists, P.A., and Babu Rao Paidipalli, M.D., on June 25, 2014, commencing at approximately 1:30 p.m., before Iva L. Talley, Court Reporter for the State of Tennessee.

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EXHIBITS

VIDEOGRAPHER: This is the beginning of the videotaped deposition of Dr. Jason Kennedy. Today's date is June 25, 2014. The time indicated on the video screen is 1:28 p.m. The standard introduction has been waived by agreement. The court reporter will now swear in the witness.

JASON D. KENNEDY, M.D.,
having first been duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. GILMER:

Q Would you state your name for the record, please?

A My name is Jason Duane Kennedy.

Q All right. Dr. Kennedy, we're here today to take your deposition in the matter of Lovelace vs. Paidipalli and Clemons.

You have been identified as an expert for the plaintiff. So today is the opportunity for us to ask questions to learn all of your opinions that you have in this case, because we don't want any surprises at trial. Okay?

A Okay.

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JASON D. KENNEDY, M.D. JUNE 25, 2014

Q Do we have an agreement that if you don't understand my questions today that you'll ask me to clarify so that we make sure that we're on the same page?
A Yeah.
Q Have you ever given a deposition before?
A I have given a deposition before in relationship as a material witness when I was 21 years old, as a paramedic. And that's it.
Q Okay. As a -- and what did that case involve?
A It was a medical malpractice case against a nursing home in which, as a paramedic, I witnessed something.
Q Okay. And were you named as a party in that case?
A No, sir, I was not.
Q Okay. Is that the only deposition that you've ever given?
A It's the only deposition I've ever given that I can recall.
Q Okay. And there are a number of ground rules. And I don't know if Mr. Ledbetter has gone over those with you, but the first is obviously that you tell the truth; you're sworn under oath today to do

that. The second is that we make sure we understand each other. And we've talked about that. And the third is that we make sure we have a clear record for our court reporter here.
A Okay.
Q So if you'll wait for me to finish my questions, I will try to wait for you to finish your answers before I ask another question.
A Yes, sir.
Q And if you'll continue to give us verbal responses -- no head nods or uh-huhs or uh-uhs, okay?
A Yes, sir.
Q All right. Is this your office that we're in today?
A This is the Critical Care office. My office is actually in a different building.
Q Okay.
A This is the closest meeting room I could find.
Q Which office is your building? I mean which building is your office in?
A My office is in the Medical Center East, North Tower, fifth floor.
Q Okay. And is -- what department is that?

A It's in the Department of Anesthesia.
Q And is the Department of Pediatric Anesthesia included in that building?
A The Division of Pediatric Anesthesia is under the Department of Anesthesia, yes, sir.
Q And so is it contained in that same building?
A The offices are in different locations, so the Department of Anesthesia has offices in multiple buildings, just from the size of the department.
Q And it's my understanding that you do not work in the Department of Pediatric Anesthesiology.
A I do not work in the Division of Pediatric Anesthesiology.
Q Which division do you work in?
A I'm a cardiac anesthesiologist caring for adult patients undergoing cardiac anesthesia and for adult patients undergoing critical care. I'm an ICU physician, also.
Q And how long have you been in that role?
A I've been in this role for four years now at Vanderbilt.
Q So that takes us back to 2010?
A Yes, sir.
Q Okay. And what have you done to prepare

for your deposition today?
A I've reviewed the medical records that I received initially that included medical records from Le Bonheur Children's Hospital. I've reviewed the depositions of -- from both defendants, and the depositions, the expert opinions of the medical experts that were sent to me. And I'm trying to think of what else I've reviewed.
Q Have you reviewed the depositions of both parents?
A I do not recall seeing those, no, sir.
Q Have you reviewed the deposition of Kelly Kish, the PACU nurse?
A I have.
Q When did you review that?
A I think I initially reviewed it probably about a month ago, and then I reviewed it again, I think, earlier this week.
Q Have you reviewed the deposition of Dr. Peretti?
A I don't recall that. There are several physicians that I reviewed, and I don't remember him specifically.
Q Peretti is identified as the forensic pathologist in this case on behalf of your side. Have

you seen his deposition transcript?
A I saw the autopsy report, and I don't -- I think that might be -- if that's what you're referring to, yes, I have seen that.
Q But we had -- we took his testimony a couple of weeks ago, and I don't think it's been drawn up yet. So I don't know if you --
A No, sir --
Q That's what I'm trying to clarify.
A -- I don't recall seeing that.
Q Okay.
A No, sir.
Q And what about the plaintiffs' economist, Dr. March, Jay March.
A No, sir, I have not.
Q When you reviewed Nurse Kish's deposition, did that change or modify your opinions in any way?
A I cannot recall that it changed or modified my opinions in any way.
Q Prior to reviewing her deposition, you had already formulated your opinions in this case?
A I had formulated an opinion in this case, yes, sir.
Q Well, after reading her deposition, did

you formulate any additional opinions?
A I can't think of any change, based upon the medical facts that were already present, that what she said changed that.
Q So her testimony did not modify, change, or affect your opinions in any way?
A I think her -- I can't think of -- no, sir.
Q Had you reviewed the order that she had entered into when she lost her license for the care that she provided in this case?
A The order? I do remember reading that, yes, sir.
Q And so did you have that knowledge base when you formed your opinions in this case?
A No, sir, I did not.
Q Okay. Now, we have had propounded to the attorney for the plaintiffs a second notice to take your deposition. Now, I understand we had your deposition notice previously, and you had a case of pink eye?
A I did, yes, sir.
Q Okay. I'm glad that got cleared up for you.
A [Laughs].

Q Now, between -- what did you do to prepare for your deposition the first time it was scheduled?
A The same series of events. I reviewed the available records that I had received, including the depositions. I had went back and reviewed what the current standards of care are within the anesthetic practice of patients undergoing anesthetics, specifically with sleep apnea, and I had reviewed specifically that in relationship to pediatric patients.
Q Where did you review something concerning what the standards of care were regarding pediatric anesthesia in this particular case?
A Multiple sources, including -- I think it's called -- there's a textbook. There's Miller's Anesthesia, which is a general anesthesia textbook, but it has sections about pediatric anesthesia. It's written by experts in pediatric anesthesia. And then there's two or three pediatric-specific textbooks.
Q Which textbooks are those?
A I would have to get back to you. I can't remember the name right offhand.
Q Prior to reviewing Miller's and those other three -- which I would ask that you supplement

and provide Mr. Ledbetter with the list of those three texts -- prior to reviewing those, were you familiar with what the recognized standard of care was for a pediatric anesthesiologist?
A I was.
Q Okay. Do you consider Miller's and the other texts that you reviewed as reliable and authoritative in establishing the standard of care for pediatric anesthesiologists?
A I would consider them reliable. I don't -- I would say there's not a single authoritative text, per se, but multiple sources.
Q What, particularly out of Miller's, did you review that you found beneficial to your opinions in this case?
A Specifically in relationship to the use of end-tidal CO2 monitoring in patients with the risk of airway compromise after tonsils and adenoid section and the risk associated with anesthetizing patients with sleep apnea, be they adults or children.
Q The other texts that you reviewed, what did you -- what subject matter did you review in those?
A The same thing.
Q And from your review of those four texts, did you find any difference in opinions?

A No specific difference in opinion that I can recall right offhand.

Q Would you agree with me that you cannot practice medicine based solely on what is included in a textbook?

A I would agree with that statement.

Q That the clinical judgment of the physician is important to the judgments that he makes in caring for a particular patient?

A I think clinical judgment is based upon sound knowledge of the available literature and data that's present to you. It's difficult to apply judgment when you don't use the data that's available to the patient.

Q Do you have any reason to believe that Dr. Paidipalli was not a sound and reputable pediatric anesthesiologist?

MR. LEDBETTER: Object as to the form.

THE WITNESS: Yeah, I'd ask that you restate the question.

BY MR. GILMER:

Q Do you have any reason to believe that Dr. Paidipalli is not a sound physician?

A Based upon my review of the anesthetic records, I would question the practices in Brett's

specific case. Outside of that, I have no other knowledge of Dr. Paidipalli's practices.

Q When you reviewed his deposition itself, did it help clarify the issues that you may have had with the medical record itself?

A My recollection of the deposition is that it shed very little light on his insight into his practice -- decisions or his understanding of the care of the patient.

Q We'll get to those in just a bit. And did you, in addition to reviewing these four texts to get up to speed on pediatric anesthesiology and sleep apnea patients and risk of airway compromise in adenoid surgery, did you review any cases -- I mean any text specific to the standard of care applicable to an ear, nose, and throat surgeon?

A I did not.

Q Now, the notice that we filed in this case asked for you to bring with you a number of things. And first of all, have you seen the notice that was filed?

A Let me review this. I do recall seeing this, yes, sir.

Q Have you met with Dr. -- I mean Mr. -- he is a JD, I guess -- Mr. Ledbetter prior to your

deposition today?

A Today is the first time I've met with him.

Q Okay. And did you speak with him by telephone prior to your deposition?

A I have, yes, sir.

Q Okay. On -- and we'll get to those in just a few minutes. How long did you meet with him today?

A Probably for about an hour.

Q And what did you go over?

A More specific?

Q What did you talk about during that hour?

A What to expect during the deposition. I've never been deposed before, so I just wanted to make certain that I was aware of, kind of, the flow and what would happen and what is the appropriate, I guess, behavior in this kind of situation.

Q Did he help you define any terms?

A I don't recall him helping me define any terms, no.

Q Prior to disclosing your opinions in this case, were you familiar with the definition of standard of care?

A Yes, I am.

Q And what -- how do you define standard of care?

A What a reasonably trained physician practicing in a similar situation would do.

Q This notice asked for you to bring with you a copy of your current C.V. And there had been one provided to me by counsel, and I was wondering if you would take a look at that and make sure that's up to date.

A [Reviews document] I think there's actually two additional publications that are not added onto here that I have not had a chance to -- I'm in the process of doing that now and I can send that to you.

Q Okay. Would you supplement those --

A I would be happy to.

Q -- afterwards? And let's go ahead, if we may, and mark the notice as 1.

(Second Notice to Take Audiovisual Deposition of Dr. Kennedy filed marked as Exhibit 1 to this deposition.)

MR. GILMER: And your C.V. as 2.

(Dr. Kennedy's curriculum vitae marked as Exhibit 2 to this deposition.)

BY MR. GILMER:

Q Would you tell us on the record what the

two publications are that are not included in your C.V. today?

A Do you mind if I look at this, please?

Q Sure.

A I believe there's one publication specifically in response to the use of echo -- transesophageal echo in patients who are hypothermic. And then there's a -- there's a book chapter that I do not have on that.

Q And what is the book chapter on?

A The book chapter is Intraoperative Monitoring of Patients' Cardiac Function During Cardiopulmonary Bypass.

Q Are any of the publications that you've listed on your curriculum vitae relevant to the issues that are at issue in this case?

A I -- I can't think of any specifically, no, sir.

Q Have you done any specific research other than the text that we talked about that you had reviewed, Miller's and the three others? Have you done any other research regarding the issues in this case?

A I just reviewed the ASA standards for the management of patients with sleep apnea, and that's about it.

Q The ASA standards that you reviewed, where did you review those?

A They are published online.

Q All right.

A They are easily able to be pulled up, even by nonmembers, on the internet, and I can provide those for you if you'd like.

Q Okay. If you would do that for us, we'll make that the next supplemental exhibit. So, so far as our -- let's do a little list here.

Our supplemental exhibits thus far are the names of the textbooks that you reviewed, your up-to-date curriculum vitae, and then the ASA standards that you reviewed online.

(Supplemental, list of textbooks reviewed by Dr. Kennedy marked Exhibit 3-A to this deposition.)

(Supplemental, Dr. Kennedy's up-to-date curriculum vitae marked Exhibit 3-B to this deposition.)

(Supplemental, online ASA standards reviewed by Dr. Kennedy marked Exhibit 3-C to this deposition.)

BY MR. GILMER:

Q And when we say AC -- ASA, I'm sorry -- we're talking about the American Society of Anesthesiologists?

A Yes, sir.

Q Are you a member of that organization?

A I was at one time. I think I've let my membership lapse.

Q And so that would be incorrect, that that's listed on your C.V. then, right?

A I don't know. I think it's like coming up for renewal within the next couple of months. I honestly don't have -- recall where I'm at with that.

Q Okay. Let's walk through your C.V. just for a second.

A Yes, sir.

Q And I'll hand you this.

(Document passed to the witness.)

BY MR. GILMER:

Q Now, describe for us -- first of all, how old are you?

A I'm 40.

Q And where are you originally from?

A I grew up for the most part in Birmingham, Alabama.

Q Where did you attend college?

A I spent one semester at Jacksonville State University, and then I completed my bachelor's degree at the UAB, which is in Birmingham, Alabama.

Q And why did you leave Jackson State?

A My parents got divorced, and my father

got -- there were just a lot of family problems.

Q Do you have any physicians in your family?

A I do not.

Q Are you related to Mr. Ledbetter in any way?

A Not that I'm aware of.

Q Do you know how you were assigned this case from Mr. Ledbetter or how he got your information?

A I don't know. I remember I got a call from him. I honestly can't -- I know it was somebody, but it's been over a year ago. I don't remember right offhand.

Q Okay. You -- I show that you received your MD in medicine from UAB?

A Yes, sir.

Q And that was in the year 2003?

A Yes, sir.

Q Then tell us briefly about -- where did you do your internship?

A I did a rotating internship at Carraway Methodist Medical Center, which is a private hospital in Birmingham -- it's no longer open -- where I worked on multiple services, including internal medicine, cardiac surgery, anesthesia, family practice, also.

Q During that internship, how long was your rotation in anesthesia?
A It was one month at the very end.
Q Did you do a rotation in ear, nose, and throat surgery?
A Did not.
Q Did you do a rotation in surgery?
A I did a rotation in cardiac surgery.
Q Since that rotation in cardiac surgery, have you done any additional work in surgery?
A Other than being in the operating room on a daily basis as an anesthesiologist caring for patients who undergo all types of surgeries, including ENT, cardiac, orthopedics, and you name it, the kind of surgery, that would be it.
Q But you don't actually --
A -- operate.
Q -- do the operating, do you?
A I occasionally do some minor procedures, but --
Q Such as?
A ECMO cannulation, which is a type of artificial heart/lung machine that is done usually percutaneously.
Q Okay.

procedures that they don't do are liver transplants, at the time -- and they have changed that since. And the other one is pediatric ortho onc, which means young children that have malignant tumors of their bones. And we did that at UAB.
Q Okay.
A And there was a limited number of people that did those procedures, and I was one of those.
Q And so those would be the only two types of pediatric patients that you would have worked with?
A At that time, yes, sir.
Q Okay. And then you did a fellowship in critical care at Emory?
A Yes, sir, I did.
Q And so that the jury understands, tell the jury what the difference is in a residency and a fellowship.
A A residency is your primary training, so if you wanted to be an internist, a primary care physician, you would do your residency in internal medicine or family practice. Then if you wanted to be, for instance, a cardiologist, you would have to have done your residency in internal medicine. And then a fellowship specializes you in one specific area.
It doesn't negate your previous training

A I'm the program director here at Vanderbilt, and so I do that.
Q Okay. Your residency in anesthesiology was also at UAB?
A Yes, sir.
Q And when you completed your residency there, you did a fellowship in critical care anesthesiology at Emory; is that right?
A Prior to going to Emory, I spent one year as an instructor in anesthesia caring for patients of basically all ages at UAB. As an instructor, that is -- you work as an instructor your first year, and I spent one year there.
Q Tell me what being an instructor means.
A You're -- you teach residents and fellows, and you're the attending of record for all the patients that you're caring for. There's no differences in your responsibilities to the patients or to the residents or fellows any different than someone who is an associate or assistant or full professor.
Q During that time, how much time did you spend at the -- was there a children's hospital there?
A There is a children's hospital in Birmingham. The interesting thing is that they don't do certain types of procedures there. And two of those

as a general anesthesiologist or as an internal medicine doctor as, for instance, a cardiologist. The same could be said for a pediatric anesthesiologist.
It's actually not a recognized boarded specialty. You don't get boarded in pediatric anesthesia currently. That's just an additional training without any board certification associated.
Q But there are fellowships available in pediatric anesthesiology?
A There are.
Q And you did not do one?
A No, sir.
Q And then after you completed your critical care anesthesiology residency, which -- what does critical care anesthesiology mean to you?
A Critical care anesthesia is accepted to mean basically the care of patients in an intensive care unit. So those patients, both postoperatively -- but, also, that come in -- not related to any type of surgical procedure -- that require care in the intensive care unit.
And in that fellowship, not only did I do that, but part of my responsibility was to rotate it with different medicine and subspecialties in the care of patients within the hospital outside of the ICU.

Q And then you did a fellowship in cardiothoracic anesthesiology at Emory?
A Yes, sir, I did.
Q And did you go to Emory thinking that you would do two fellowships?
A I -- that was my initial plan. My initial plan was to do a third in congenital pediatrics, but from a financial standpoint and a life standpoint, my wife had had enough.
Q I can understand.
A She said go get a job.
Q And cardiothoracic anesthesiology is what you chose to continue on doing; is that right?
A I practice both.
Q You do practice both?
A I do practice both.
Q How is your practice divided between critical care and cardiothoracic, or do they just overlap on a repetitive basis?
A So when I'm assigned -- we have a schedule going out anywhere between two to six months. And so I will be assigned to be in the cardiothoracic ICU here where we're -- the Intensive is for a 27-man ICU. And when I do that, that's my primary responsibility.

I will occasionally cover people or take care of people who are having cases done just in a suite right outside of our ICU, but for the most part, I care for those patients for that week, and I'm on 24/7 for that week. And then I usually have some non-clinical days after that.
And then I'll be in the operating room, so that my time -- when I'm in the operating room, I'm dedicated to caring for patients who have any number of cardiac or other procedures because we cover a number of different locations in the hospital.
Q In either of those roles, do you work with pediatric patients?
A No, sir, not currently.
Q The university has a division of pediatric anesthesiology in addition to your division of cardiothoracic anesthesiology?
A They do.
Q Have you applied to be in that division or ...
A No.
Q Okay. Do you have any interest in working in pediatric anesthesia?
A Not currently, no.
Q Now, you are not board certified?

A I am board certified in adult anesthesia.
Q Okay.
A I am board certified in critical care medicine, and I'm board certified by the American -- what is it, American College of Echocardiography for -- board certified in echo. So I'm triple boarded.
Q Okay. Did you pass your boards on your first attempt?
A I passed my boards my second year of residency.
Q Second year of residency?
A Yes, sir.
Q Okay. Did you pass the written and the oral on your first attempt?
A I did.
Q Now, when you practiced in Alabama, were you licensed to practice medicine there?
A I was, yes, sir.
Q Okay. And was that license through the medical school, or do you have a separated medical license in Alabama?
A So Alabama has a training license, and I had that as a resident, but as a faculty member, when I was an instructor, I had a full non-training license.

Q Do you still have a license in Alabama?
A I let my license in Alabama expire because I have no intention of going back to Alabama.
Q Okay. And you have been licensed in Tennessee since June of 2010?
A Yes, sir. That's when I got here.
Q And that's when you got to Vanderbilt?
A Yes, sir.
Q Have you worked at any other hospitals in Tennessee?
A No, sir.
Q Have you ever worked at or done grand rounds or any type of teaching in Memphis?
A No, sir, I have not.
Q Have you ever been in a hospital in Memphis?
A I don't think so.
Q Have you ever met an anesthesiologist from Memphis?
A I think I have in a couple of meetings, but I couldn't tell you their names.
Q Have you had any conversations with any anesthesiologists that are familiar with the practice at Le Boneur Hospital?
A Like I said, I've probably met several

anesthesiologists at different meetings that I've attended, but I couldn't tell you their names.

Q And during those meetings, did you discuss the maintenance of the airway following a post-adenoidectomy?

A I don't recall what we talked about.

Q What are your current teaching responsibilities here at Vanderbilt?

A Currently, I am responsible for teaching all general anesthesia residents while they are on the cardiothoracic rotation. So they do two to four months on that, from an anesthetic standpoint.

We also have fellows who are subspecializing in cardiac anesthesia, and I'm responsible for teaching them both the care and management of those patients but also the use and interpretation of transesophageal echo in the operating room and outside the operating room.

I'm also responsible for teaching our fellows in the ICU, our critical fellows, those -- so those are anesthesiologists who have completed a year -- I mean, the four years of training in anesthesia, who are doing an additional year of training for critical care. So I'm responsible for that.

Up until about two months ago, I oversaw the training program for echo, echocardiography, for our fellows. And I'm taking a temporary leave of that for right now. And that's, I think, about it.

Also, we have medical students that rotate. Frequently, we have several different courses that the medical students now take through our department, and I participate in that.

Q How many other -- well, let me back up. Do all the members of your department also have teaching responsibilities like you?

A It's a -- yes, sir.

Q Being a teaching institution, everyone that works here teaches; is that right?

A Yes, sir.

Q Okay. And your teaching, is that classroom teaching, or is that rounding on patients in an operating-room-type setting, teaching?

A We do some lectures. Usually, it's not large lectures of all the residents at one time. Usually, it's smaller group lectures, so small -- kind of small group discussions. I've done some grand rounds here.

Also, I've had some lectures with the entire residency class, but that's not very common

nowadays. Most of my teaching is bedside teaching with residents and fellows in the -- both at bedside, but in the operating room.

Q Transesophageal echo, is that -- did I say that right?

A Yes, sir, you did.

Q And what is that exactly?

A That is the use of an ultrasound mounted on a -- kind of a gastroscope that goes in the mouth, through the esophagus, and you image the heart, and usually, you can also image the lungs. Primarily, it's the heart, and you look at cardiac function using that.

Q Is that your primary interest here at Vanderbilt?

A That's one of my many interests at Vanderbilt.

Q Okay. The presentations that you've given, have any of those been related to the subject matter at issue in this case?

A I've discussed thoracic anesthesia at a recent conference, and it was -- you know, it's dealing with the airway management, but not specific to tonsils and adenoids.

Q And not specific to pediatric patients?

A No, sir.

Q Back to your notice here, it also asks you to bring with you any and all records and notes that you have generated while working on this case. Do you have those with you?

A I have them in my office.

Q Okay. And --

MR. LEDBETTER: Let me respond. I said at the beginning of this that I had filed an objection to this listed item, to all these listed items, similar to the objection that had been filed on behalf of Dr. Paidipalli.

And I didn't want to have to get into the issue of Rule 30, 34, or 26, and the fact that our discovery cutoff has lapsed and that this request came seven days in advance of this and it's untimely, but I'm reiterating that only because this witness did not have this list and was not told to bring this list.

You can ask him about these items, but we're not producing them, nor do I understand that you intend to produce them from your witnesses.

BY MR. GILMER:

Q Dr. Kennedy, what -- I have a disclosure that was provided to us in this case. It's called an expert witness report.

A Yes, sir.

Q And in addition to this expert witness report that we have here, what other records and notes have you made in this case?

A I've got just a couple of things I wrote down here this morning when I was looking at -- that's Smith's, Smith's Anesthesia. That's one of the other books that I have.

Q Okay.

A And that's really it.

Q Let me see that.

A Here, that's about all I've got.

(Witness passes document to counsel.)

BY MR. GILMER:

Q Was this something that you pulled from the internet?

A This is something I pulled off of -- we have digital textbooks. No one makes textbooks anymore because it's just a lot of wasted trees. So all of our textbooks are now computerized, so I just pulled this off, this textbook, that is considered probably -- I won't say the authoritative textbook on pediatrics, but one of the authoritative textbooks on pediatrics.

Q And do you believe that the information contained in this text is authoritative and reliable?

A I believe it's reliable, and it's an

often-referenced opinion by practicing pediatric anesthesiologists.

Q Do you believe it establishes what the standard of care is for pediatric anesthesiologists?

A I think it helps to establish the standard of care. The standard of care is associated with a lot of different things.

MR. GILMER: Let's mark this as our next exhibit, please.

MR. LEDBETTER: No objection.

(Document entitled "Smith's Anesthesia For Infants and Children, Eighth Edition," marked Exhibit No. 4 to this deposition.)

(Off the record.)

MR. GILMER: I did want to clarify one thing on the record. Mr. Ledbetter made a statement about receiving a notice seven days prior to the expiration of a deadline.

BY MR. GILMER:

Q This -- the original notice to take your deposition was filed on May 22nd and contained the same list of items that I have today. Did you see the original notice?

A I honestly don't know.

MR. JOHNSON: That's the pre-pink eye.

THE WITNESS: Yeah.

BY MR. GILMER:

Q Let's mark the original notice as our next exhibit, please.

(Notice to Take Audiovisual Deposition of Dr. Jason Kennedy filed May 22, 2014 marked Exhibit No. 5 to this deposition.)

BY MR. GILMER:

Q Now, the text that you pulled to review in this case -- when did you pull this?

A I just happened to pull it this morning just before I walked over here.

Q In addition to this Smith's Anesthesia section that you have here marked as Exhibit 4, what other notes and records did you generate with respect to this case?

A I think I jotted down a couple of things on paper, but I don't remember where they are at right now.

Q Do you still have those things?

A They are probably at my -- either at my home office or in my office over here.

Q Okay. I would ask that you -- subject to plaintiff's objection, I would ask that you preserve those and not destroy that evidence because we may be

entitled to that down the road.

A Okay.

Q The notes that you made, what did they say?

A Mostly, I was trying to develop a time line of what happened. And then I -- that's kind of -- I was trying to figure out through digging through all those record-s, because it's quite voluminous, and I was just trying to find out what were the course of events.

Q Were you able to put together what you thought was the course of events?

A I was able to piece together, as best as I could.

Q What other notes and records did you generate besides that?

A That's probably about it.

Q Okay. Did you communicate with Mr. Ledbetter via email?

MR. LEDBETTER: Objection to questions concerning communication under Federal Rules. They pertain to expert witnesses. You're not allowed to get into communications unless they are under certain circumstances, and your question does not address those circumstances.

BY MR. GILMER:

Q Did Mr. Ledbetter give you any facts or opinions related to this case before you formulated your opinions in the case?

A No, he didn't.

Q What did he provide you with originally so that you could form your opinions?

A I think he just sent me the copy of records from Le Bonheur Children's Hospital, and that's it.

Q And then at separate times, did he then send you the depositions as they were completed?

A Yeah. That was quite a bit later.

Q But he did not send you the parents' depositions?

A I don't recall seeing those.

Q Did you know the parents were in the PACU during the entire time that this -- that the child was there?

A I remember seeing something to that effect that for a good portion of the time that the parents were there. I didn't know if it was all or just part of it.

Q Did you see the pictures that they took?

A I did.

Q Okay. Did you keep time records in the case of how much time you expended?

A Uh, yeah. They were probably not to the minute, but general records, yeah.

Q Okay. And have you -- how much time have you spent thus far on this matter?

A Probably -- up until today, probably about twelve hours.

Q When you initially got the medical records, how much time did you spend reviewing those?

A Probably an additional four or five hours, just trying to go through.

Q And then the time since then was reviewing Dr. Clemons and Paidipalli's depositions?

A And then go back and tie that in with the medical record and seeing how they related.

Q Have you billed him yet for your time?

A I have.

Q Okay. And how much have you billed him thus far?

A I think twelve hours. I think it was $4,200, whatever that is. I've not done the math in my head.

Q I did receive an addendum to your expert report -- which I have marked up my copy of it. But

let's make sure we agree to two things. The first is that you have never given a deposition before --

A I have never --

Q -- other than as the paramedic?

A That's the only one that I can recall, and I'm trying to remember. I was a witness in a car accident and I had to go to court for that. And that's about it.

Q Okay. And this is your first case testifying as an expert witness?

A It sure is.

Q Have you reviewed any cases prior to this in a role as --

A No, sir.

Q -- an expert?

A Not prior to this.

Q This is the first one that you've reviewed, the first one you've testified in?

A The first one I've reviewed, the first one I've testified in, yes, sir.

Q And your time -- you charge $350 per hour for review?

A Yes, sir.

Q And then $500 an hour for your testimony?

A Yes, sir.

Q Okay. And do you -- is it at Vanderbilt -- does the money go to Vanderbilt, and then they recompensate you or --

A Huh-uh, no.

Q It goes to you directly? Okay. And do you think you have submitted one or two bills to Mr. Ledbetter?

A I think I've only submitted one.

Q Did it include the time for your preparation for today's deposition?

A I think I prepared for another two hours. Just this morning, I got in and just -- I wanted to look through everything again and what I pulled up here, which was probably another hour or so, I guess, for that.

Q Do you intend to come to trial to testify?

A I guess, if subpoenaed, I will.

Q All right. So you only intend to come if you're subpoenaed?

MR. LEDBETTER: He's coming.

THE WITNESS: If asked to come -- I don't have to be subpoenaed. If I'm asked to come, I'll be happy to come.

BY MR. GILMER:

Q And what will you charge for your trial testimony?

A I've honestly not put into any thought into that.

Q Okay. Will you charge the same $500 per hour, or will you have a minimum or a maximum?

A Sure. Actually, I mean I don't want to agree to any --

Q Well, you can charge him as much as you want to. I just am trying to figure out what --

A I have no -- I have put zero thought into it.

Q Okay.

A I'm not doing this for any financial reward.

Q Okay. Well -- well, if you're not doing it for financial reward, why are you doing it?

A Because I think part of the process as physicians is that we have to police ourselves.

Q Is there any mandate at Vanderbilt that you testify against other physicians?

A Nope.

Q Does the ASA have standards as to serving as an expert witness?

A They do, and I've looked at them before. And I don't -- I couldn't quote them to you, but basically, it's do the right thing, give your opinion to the best of your ability, and be honest and faithful to what you know.

Q Do the -- does that standard require you to be familiar with the issues upon which you're testifying?

A Yep.

Q The depositions that you have reviewed, did you make notes in those depositions?

A I don't think I wrote on any one of the depositions. I just looked through them.

Q The medical records that you used, did you put sticky notes on them or make any notations on the records themselves?

A I had a disc. It was on a disc.

Q Okay.

A On, like, a PDF. And so no, I didn't.

Q Did you -- you didn't use the Adobe modifier to add notes or --

A No. I'm pretty computer illiterate sometimes.

Q Okay.

A I'm sorry.

Q That's fine. Have you reviewed any specific guidelines from the hospital itself regarding their policies and procedures?

A I remember asking for one when I first saw this for their PACU care. And I remember -- I think I remember reviewing it, but that's been, like I said, over a year ago. And, basically, I think what I got was their PACU order set is what I got.

Q And did that provide you with any basis for your opinions in the case?

A It did.

Q What specifically?

A Relating to the administration of oxygen.

Q What specifically about the administration of oxygen?

A That oxygen was to be administered to patients upon a physician's order and when indicated and to maintain certain saturations.

Q And did you -- do you believe that oxygen was not used in the PACU?

A It was my understanding, by reading the deposition, that oxygen was not used in the PACU.

Q And what is your understanding from reading the depositions regarding the ability of the PACU nurse to use supplemental oxygen?

A You have to restate your question, please.

Q From reviewing the testimony in the case and the PACU orders that you reviewed, is it -- do you have an opinion as to whether the PACU nurse herself could apply oxygen, if needed?

A I've never been in a hospital where someone can't apply oxygen --

Q Someone --

A -- if needed.

Q Someone --

A Anyone. I mean a nurse or a physician.

Q Anyone can?

A Anyone caring for a patient can apply oxygen.

Q Including Kelly Kish?

A Including the nurse, Kelly Kish, yes.

Q Now, No. 5 -- my No. 5 request of -- I think we've gone over everything that you've reviewed. We have talked about the records that you reviewed. We've talked about the depositions that you reviewed. Did you -- by the way, did you review any of Brett's school records or records from other providers besides Le Boneur?

A No, sir, I have not.
Q Now, you did read Dr. Peretti's independent autopsy report?
A I read an autopsy report. And I couldn't tell you the name of the physician at this point.
Q All right. When you read his record, was there anything that you disagreed with?
A I can't recall anything offhand that I would have disagreed with.
Q We've talked about the medical text that you've reviewed and the PACU orders that we just talked about. Are there any other writings or records that you reviewed to help formulate your opinions in this case that we have not talked about?
A Let me sit here and think about it. I can't think of anything. No, sir.
Q And this is an ongoing thing. If -- the way you just answered that question, if at some point today --
A I'll let you know.
Q Just let me know. And even if you remember after the deposition, can we have an agreement that if you remember something differently or remember the answer to something, that you'll let Mr. Ledbetter

know so that he can --
A Sure.
Q -- let us know?
A Absolutely.
Q Because Mr. Johnson and I do not want to be surprised by anything that you come to trial to talk about, okay?
A That's reasonable and fair.
Q All right.
MR. LEDBETTER: One comment. And this is not to inform the witness, but he cites some sources in his report but you haven't asked about them. I assume that --
MR. GILMER: I'll go through those.
MR. LEDBETTER: -- he's not misled you by not saying -- there may be other things that he's cited.
MR. GILMER: That's --
MR. LEDBETTER: Are you okay with that?
MR. GILMER: That's fine. Yeah, we'll talk about those specifically when we go through your record.
BY MR. GILMER:
Q Number 7 -- I think we may have covered this, but I'm not sure. Have you been sued before?

A I've never had a malpractice suit against me or any other suit that I can -- no.
Q When you were a resident, was any of care that you provided the issue -- at issue in a lawsuit?
A Not that I'm aware of, no.
Q And have you ever had to make a claim before a lawsuit was filed? In other words, someone threatened to sue you, and you talked to your insurance carrier and made a claim about it?
A No. I've never settled or anything like that.
Q All right. And this is your first try at being an expert witness; is that right?
A Yeah.
Q Now, the report that was eventually provided to us, which we'll -- why don't we go ahead and mark the plaintiff's designation of expert witnesses and physicians not employed as experts as the collective next exhibit.
(Collective, Plaintiff's Designation of Expert Witnesses and Physicians Not Employed as Experts marked as Exhibit No. 6 to this deposition.)
BY MR. GILMER:
Q And within this collective exhibit is?

MR. LEDBETTER: Is that Exhibit 5?
MR. GILMER: Yes -- this is Exhibit 6.
MR. LEDBETTER: Six, okay.
BY MR. GILMER
Q Within Exhibit 6, there is Exhibit C, which is your expert witness report.
A Yes, sir.
Q Now, did you prepare this yourself?
A I prepared it myself. The exact wording, some of it, Dr. Led -- I mean, Mr. Ledbetter helped me with.
Q Okay. And did you have previous drafts of this report that you did before this final one was published to us?
A I think that I had one that I sent to him, but I can't remember right offhand.
Q Do you remember what changes you and Mr. Ledbetter discussed?
A I don't remember exactly what it was right offhand, no.
Q Well, when we're going through your report in just a few minutes, then, I want you to tell me if you remember anything that changed or anything along those lines, and we'll talk about some of the things that Mr. Ledbetter may have helped you with on

those.

MR. LEDBETTER: Object to that commentary.

MR. GILMER: I'm sorry. I thought he'd just said that you had helped him with some wording on some of it.

BY MR. GILMER:

Q All right. I think that concludes the notice itself. Do you have staff privileges at any other hospitals besides Vanderbilt?

A No.

Q And does -- Vanderbilt has a children's hospital, does it not?

A Yes, sir.

Q And do you put patients to sleep or round on patients over there?

A No, sir.

Q Have you ever?

A No, sir.

Q Have you ever applied for staff privileges anywhere else?

A I applied for staff privileges at UAB and received them. I've never applied for staff privileges at any other hospital and been denied.

Q Okay. We talked about your license here

in Tennessee, and you had a license in Alabama that lapsed. Prior to the lapse in Alabama, was your Alabama license ever revoked, suspended, denied, or put on probation?

A No, sir.

Q The same for Tennessee; have you had any of those issues here?

A No, sir.

Q Do you have a DEA number?

A I do.

Q And what is that number?

A Uh ...

Q Do you remember?

A I don't a), remember right offhand, and b), I'm not sure that I would give it to you even if I did remember it, because I use that for prescribing controlled substances.

Q Okay. And has your DEA number ever been affected?

A No.

Q Okay. You've never been sued. And have you ever put a patient -- a pediatric patient to sleep for an adenoidectomy?

A I have.

Q Okay. And when was that?

A 2000 -- probably '4, I'm thinking through 2005, 2006, when I was a resident.

Q 2004 through 2006?

A Probably so, yeah, about.

Q And about how many of those procedures -- or we can even broaden it to adenoidectomy, tonsillectomy, any type of throat surgery on a pediatric patient?

A Probably in excess of fifty.

Q In 2012 and the year preceding that, 2011, you did not do any of those procedures, though, correct?

A What do you mean?

Q In 2011 and 2012, you did not put any pediatric --

A No, sir.

Q -- patients to sleep, did you?

A No, sir.

Q Have you ever put together a twelve-year-old boy that weighed 81 kilos for a pediatric ...

A Sure, I have.

Q Okay.

A Yeah.

Q And you consider yourself an expert in

what fields of medicine?

A Anesthesia, cardiac anesthesia, critical care anesthesia, echocardiography.

Q Anything else?

A I'm program director of ECMO. So I don't -- that's E-C-M-O. There's no "h" on it.

Q Oh, got you. That's right. Don't pay attention to my notes. I've got terrible note-taking skills.

The opinions that you expressed in this case are also -- you're giving opinions about the standard of care for an ENT physician. Do you believe that you have expertise in that field?

A I don't recall giving an opinion about the practice for an ENT physician. I gave an opinion about the practice of a physician who saw a patient in distress or in an abnormal position. No comment about his practice as an ENT surgeon.

Q What is the -- been the nature of your practice, primarily, since you came to Vanderbilt? Can you just give me a thumbnail sketch of what your years are like?

A I'm sorry. I don't --

Q Do you see patients -- as an anesthesiologist, you don't have clinic patients, do

you?
A I do not have clinic patients.
Q Okay.
A Though I occasionally see patients in the clinic on the request of their specialist for the preoperative evaluation of those patients. I do that. So yeah, I have seen an occasional patient in clinic, trying to determine their fitness for anesthetic.
Q Is your practice -- how much of your practice is clinical versus teaching?
A Uh --
Q Or is all your teaching subsumed in --
A Yeah, I'm a --
Q -- your clinical practice.
A There's different tracks within Vanderbilt. I am a -- I'm a clinician. I mean that's what I do. I'm not a researcher. I've published a little bit. I take part in that, but mostly on my own time. But I'm, primarily and foremost, a clinician.
Q Do you believe that there's any additional information out there that would be helpful to you in making sure that your opinions are accurate that you've given in this case?
A I'm sure there's always additional data that we don't get on any given point, but it's not -- I

can't think of anything right immediately that I'm running out to go get.
Q Is there anyone you'd want to hear from with respect to what they saw or did that you have not seen or read?
A I think it would be probably beneficial to get the depositions of the operating room nurses that cared for the patient to determine if there are some holes in the depositions of some of the named previous depositions that don't make sense as far as, you know, who transported the patient to the PACU recovery area and what the patient's condition was when they were extubating.
Q Anything else that you consider to be a hole, so to speak?
A It would be interesting to look at the parents' depositions -- I have not seen that -- and whoever was involved with the cardiac arrest effort that occurred. That might be helpful, but at that point, the damage was already done, so it's probably not as relevant to what happened intra-operatively, which led to this.
Q Have you discussed this case with anyone other than Mr. Ledbetter?
A I have not.

Q Have you had any firsthand contact with the parents?
A I have not.
Q Have you talked with any other physicians about the facts of this case?
A I have asked another -- I've asked a pediatric anesthesiologist her opinion regarding a prone position in a post-recovery that had changed. And that's about it.
Q Who was that?
A Hold on a second. I'll tell you right now. Heidi Smith, Dr. Heidi Smith. You put me on the spot.
Q And, again, what did you talk to her about?
A I specifically asked her about positioning in the postoperative recovery patient. She had no other facts of the case, just --
Q What did she have to say?
A That she would never routinely allow a child to go prone, of his size.
Q What about semi-prone?
A A semi-lateral position?
Q (Nods in the affirmative.)
A That is completely -- that's called the

recovery position, but in a prone position, in a knee-to-chest, no.
Q Did you bring your medical records with you today?
A I did not.
Q Have you had -- are you reviewing any other cases as an expert witness right now?
A I was asked to review a case one week ago. I just got the records.
Q What -- by whom were you asked?
A One of my senior partners is a physician that has done previous medical/legal work and referred the patient -- or referred an attorney to me in regards to something that I do frequently.
Q And is that a case that you're being asked to review on behalf of a patient or on behalf of a doctor?
A I actually don't know who -- they didn't tell me. They just gave me the -- all they asked me to do is look at these records, and I'm looking at the records.
Q Does it involve a child?
A It involves an adult.
Q Do you advertise yourself as being available to be an expert witness?

A No. Sometimes I ask myself why did I agree to do this.

Q And you don't know how Mr. Ledbetter got in touch with you?

A I can't remember right offhand. I was thinking about that this morning because I figured you would ask me that. But I don't really recall how.

Q Do you remember when your first contact from him was?

A Over a year ago. I'm sure you could tell me when.

Q And would that be contained in some type of correspondence that he had with you?

A Probably an e-mail or probably in the -- I guess I have an envelope that had the disc in it that he sent me with the medical records.

Q Do you remember what your first contact with him was about, like what was said, what was referenced, that sort of thing?

MR. LEDBETTER: Again, I renew my objection to communications under Federal Rules.

BY MR. GILMER:

Q Did he give you any of the facts of the case?

A No.

Q Did he simply send you the -- did he send you the complaint?

A No.

Q Just the medical records?

A As far as I remember, he sent me the medical records.

Q Other than the report that we've referenced here under Exhibit 6 that you did, did you make any other reports in this case?

A No, sir.

Q Were you asked to sign any affidavit or anything of that nature?

A I think so. I don't think I sent it. I think that's the report, right?

Q Okay. Let's talk about this case specifically now that we've gone through all of that. Give me a brief summary of the facts that you think are significant to this case.

A Brett was a twelve-year-old boy with, I think, some learning issues, developmental issues, that presented for a tonsillectomy/adenoidectomy to Le Boneur Children Hospital. He had a known history, by report, of symptoms consistent with sleep apnea, specifically snoring and gasping breaths.

His physical exam was consistent with

someone who would have sleep apnea and put him at high risk. If I recall right, he had some mention that he had asthma or wheezing as a child, and he was on a nebulizer and took a bronchodilator.

He underwent a tonsillectomy and adenoidectomy under general anesthesia using an endotracheal tube, using an inhalation induction, you know, with a peripheral I.V. placed.

He had 200 milligrams of propofol, 100 milligrams of Lidocaine, 100 micrograms of fentanyl, with a sevoflurane induction, starting off at 8 percent, and titrating down to about 3 percent.

His initial heart rate prior to induction was about 70 and his baseline CO2, after intubation, was about 40, with tidal volumes of about 450, of which are consistent with normal tidal volumes for a patient his size.

At the completion of surgery, he had received no neuromuscular blocking agents, so that was not an issue. He had an end-tidal CO2 that had progressively risen through the duration of the case with tidal volumes that were down to in the 160s that are not consistent with adequate minimal ventilation for a child his size.

He was taken to the recovery room. He

never awakened and really fully emerged, by reports of the parents. He did have emergence delirium, which would be consistent with him thrashing around and moving in an uncoordinated fashion, knocking his monitors off, but that's not consistent with adequacy of respiration, ventilation, or the ability to support one's airway.

While in the recovery room, his oxygen saturation was read as normal. There were some issues with the finger probe maybe falling off. There, some concerns were raised by the parents.

At one point, the surgeon came by and saw the patient laying prone, knee-to-chest, with his face down, and asked the parents if that's how he slept and did nothing to correct the patient's obviously poor position after a tonsillectomy and adenoidectomy.

And shortly thereafter, if I remember right, at about 12 o'clock, the patient has a Code Harvey, which is their cardiac arrest called in the PACU. And Kish turned the patient over to evaluate him when she noticed that he was not snoring anymore, which the patient --

At that point in time, CPR was started. He was intubated at, if I recall right, 12:04 p.m. A blood gas that was drawn approximately fifteen minutes

later showed an arterial CO2 of 96. One done about five minutes before that showed a venous CO2 of "unmeasurable," in excess of 130. Normal arterial CO2 is 40 or so. Normal venous CO2 would be about 45.

Both of these, lab data and the Anesthetic Record, were consistent with a patient who had inadequate ventilation that led to hypoxemia and to his cardiac arrest.

He subsequently was taken to the ICU where he was cared for then. The lines were placed for monitoring and for medicine administration. And over a period, I think, of about 48 hours, which is pretty consistent with assessing brain death, he had multiple tests, including an echocardiogram; I think a blood flow study to look at his brain; and he was declared brain dead.

I think the organ donation center was contacted, but I'd want to say that they refused any visceral organs. They might have done skin and bone.

Q Any other facts that you found significant?

A The other facts that I did find as significant and relevant to the case is the way the patient was monitored in the PACU. Nurse Kish was noted to be on Facebook and using the computer. And

the parents asked her to assess him on multiple occasions, and she failed to do so.

Other issues are that Dr. Paidipalli never assessed the patient in the recovery area, which is very -- not consistent with the practice of anesthesia, to assess a patient, especially with his high risk of risk factors from sleep apnea and snoring and his body size -- an 86-k twelve-year-old boy is a very large twelve-year-old boy -- that the surgeon -- like I said, he stopped by, and other than noting that the patient was in a very poor position, did nothing to correct it.

Those are, I guess, the key -- the key salient points. There's a lot of other pieces of data that are out there that I'm sure can be interjected.

Q Do you agree that Nurse Kish never notified Dr. Paidipalli or Dr. Clemons of any problems?

A I saw no documentation of that.

Q Did you see where she notified them of -- or did not notify them, in her deposition?

A I -- if I recall right, she said that she never called them. And Paidipalli reported never being notified, as did Dr. Clemons.

Q Do you believe it is unreasonable for an anesthesiologist to rely on a trained PACU nurse to

notify them of problems with her patient?

A Can you restate the question?

Q Do you believe that it is unreasonable for Dr. Paidipalli to have relied on the PACU nurse to notify him of any problems with his patient?

A I think it's reasonable for him to rely on her to notify him. It's also part of his responsibility to check on the patient in the unit before ninety minutes has transpired and -- especially a patient as high risk as Brett was -- to convey his concerns, which were very obvious -- or they should have been obvious -- that he might have had, to make sure that Nurse Kish carried out the appropriate level of care.

Q What did the standard of care require Dr. Paidipalli to do with respect to speaking to Nurse Kish?

A To make sure that the -- an appropriate level of hand-off was performed either by himself or the CRNA in the room, that involved the patient's current and past medical history, their anesthetic course, and any surgical complications or surgical issues that developed during the care of their patient, and then to make an appropriate level of checks on the patient in the post-op recovery period.

Q How frequently did the standard of care require Dr. Paidipalli to check on a patient?

A There's no designated time, per se. It's dependent upon the patient's individual condition.

As a practicing anesthesiologist, I make it a point either to accompany every patient to the recovery room or check on them within ten or fifteen minutes to make certain, and then if there are any concerns, I make a point that the communication loop is -- is kind of closed.

My responsibility as an anesthesiologist is to supervise the care of the patient. And yes, the nurses have a responsibility, and yes, the CRNAs have a responsibility, but as a supervising physician, I'm ultimately responsible for what they do or don't do, because -- if they have a failure to do it based upon their lack of understanding or lack of knowledge.

Q Do you believe that you're the captain of the ship, so to speak?

A I believe I am the physician taking care of the patient. I have a responsibility to supervise the care of the patient.

Q In other words, do you have the responsibility to ensure that the other providers are doing their job?

A I have a responsibility while the patient is recovering from an anesthetic to ensure they recover from that. The surgeon, who also has a shared responsibility because it's -- especially since it's an airway case -- has a responsibility to at least -- you know, especially if he walked by and saw the patient in a position that's not conducive to appropriate airway support and not consistent with the standards set at Le Bonheur -- to rectify the situation or make another physician, specifically, the anesthesiologist, aware.

Q Now, we'll go back through most of those things again when we go through your report, but you mentioned something a couple of times as you were telling me what the salient facts were and it is what the parents said or did. And I was wondering how you had that information if you had not reviewed their depositions?

A I don't recall where it was at, to be honest with you. I ... it was ... I honestly don't recall.

Q Are you familiar with the standard of care for a PACU nurse?

A I'm familiar with what is involved with a PACU nurse caring for a patient, yes.

Q Is playing on Facebook appropriate while

you're monitoring a patient?

A Absolutely not.

Q Is that a deviation from the standard of care?

A I would say so.

Q Is failing to ensure that the monitors were appropriately working on a patient -- is that a deviation from the standard of care?

A Yeah.

Q Is failing to reposition a patient who is exhibiting breathing difficulties a deviation from the standard of care?

A Yeah.

Q Is failing to apply supplemental oxygen in the PACU Recovery a deviation from the standard of care if it's called for?

A That would be -- if it was called for, yes.

Q You, yourself, in going through the facts, indicated that the O2 monitoring appeared normal throughout his PACU course.

A It was charted as normal, I would say that.

Q And --

A But then there was some mention about

they're having problems with the waveform, I think, back in Kish's deposition, I think.

Q Do you believe one way or the other of whether Nurse Kish accurately recorded the O2 saturations while he was in the PACU?

A Do I believe that she accurately recorded? I think she probably accurately recorded it to the best as she was paying attention or if the monitor was working, but I don't have any reason to think that she lied, per se.

Q Do you agree that Nurse Kish was in a position to have changed the outcome of this case?

A I think there were multiple people in a position to change the outcome of this case.

Q Isn't --

A And I think she's one of them, yeah.

Q Had she notified Dr. Paidipalli of any issues that were going on, he then could have assessed the patient and perhaps changed the course?

MR. LEDBETTER: Object as to the form of the question, and also invites speculation.

BY MR. GILMER:

Q You can answer my question. He's going to make objections all day.

A Okay. I guess I would say that that

would be -- it depends on the timing. You know, I think this child was not fully awake, based upon my review of the records, when he exited the operating room.

So, you know, he was clearly very hypercarbic, and this had been going on for a while. And so that would be somewhat speculation on my part, and I'm not willing to speculate. I'm only commenting on what I saw present, based upon the medical records and my opinion.

Q Have you seen any toxicology reports or lab reports that would indicate that the patient still had anesthetic in his system at the time he expired?

A I don't remember if there was a toxicology report. The interesting thing about both Sevoflurane and Isoflurane -- and this child received Sevoflurane, which is an inhaled anesthetic -- is that it works by being absorbed. You breathe it and then it goes into the blood, but before it can actually have any effect, it has to go into the brain.

So something called the blood-fat solubility is very important. And your brain has a lot of fat in it because your neurons are surrounded by lipid -- lipid membranes, and so it's impossible to monitor that. There's no toxicology report that would

show that. So we don't monitor Sevoflurane levels.

What you do see -- and that's pretty well-documented that Sevoflurane actually is around for quite a while. The child clearly received Fentanyl -- that's documented in the Anesthetic Record. 100 micrograms, which is about 1.2, 1.25 mcg per kilo for this child, is enough even for a child his age with obstructive sleep apnea to lead him to have significant respiratory depression in the postoperative period.

The Sevoflurane definitely would cause him to have what his anesthetic record demonstrates, which is a rate of about 22 -- a respiratory rate of about 22 and tidal volumes that are small. And that's very consistent with a volatile anesthetic still laying around.

And the issue with having low tidal volume, such as that, is that there's a certain amount of what we call dead space within your lungs. In order for the air to get from here to your alveoli, where you have gas exchange, it's about 150 cc's. 2 cc's per kilo, actually, is what the norm is.

So even in Brett's situation, you would use his height and not his weight to make that determination. So we'll say about 120 cc's for him.

That -- 120 cc's of that does not

participate in gas exchange, so his effective tidal volumes were only 100 cc's, which is consistent with the medical record that clearly shows that he was quite hypercarbic at the time of his arrest, and that of --

You know, there's only so much space in your lungs, and a large portion of that is taken up by nitrogen, which is the most common gas in the atmosphere. And then when you become very hypercarbic, that CO2 actually will displace the available oxygen in your blood.

So when we give supplemental oxygen, we've trying to displace the nitrogen and just overcome any hypoxemic effects. The hypercarbia is still there. It still makes you -- it still depresses your respirations further. It still makes you much more sleepy. And if you look at Brett's anesthetic record, he had a end-tidal CO2 of 54, if I remember right.

Right before that was the last documented CO2. It could have been higher than that. And I think there was a comment on one of the expert opinions that this is not accurate. It can underestimate, but it doesn't ever overestimate your CO2 in your blood.

And a CO2 of 54 by end-tidal -- there's something called physiologic dead space. And so his

arterial CO2 at that point in time was usually no less than 6 higher, so it was at least 60. If you get a CO2 of 80, on most adults and children, you get what we call 1 "MAC" of anesthetic. It's enough sedative potency to actually -- to operate on you. Okay. So Brett was not far from that when he left the operating room, and he had that much CO2.

So to get back to the answer to your question, there's no way to monitor Sevoflurane concentrations that we do in common clinical practice. There's research ways that you can do that, and they have shown that Isoflurane, for instance, will stick around for about 96, sometimes 72 hours. You can still smell it frequently as patients come out. That balto agent [phonetic], that risk for a depression effect, is still present, though not measured.

Q End-tidal CO2 volumes change from second to second?

A It changes from not necessarily second to second, but it can change over periods of breaths. But, you know, for Brett, there was a clear marching up of his CO2. It just wasn't an isolated monitoring.

And I think one of your expert witnesses made that comment that -- you know, "this isolated measurement." Brett's was not isolated. It was --

there was a clear pattern. I mean that's what the data clearly shows, is that this child had an increasing CO2 end-tidal, which would correlate with an increasing arterial CO2, so inadequate ventilation with lower tidal volumes.

And that is part of the instruments that we use to fly the plane. You know, there's definitely a clinical judgment that goes along with this, but it would be -- I guess the analogy would be that, you know, Jimmy Doolittle flew an airplane to Japan and completed a mission with a map and a compass, but you wouldn't get onto an international 747 and not expect the pilot to use the GPS to get you from here to Europe or from here to Atlanta, whichever.

Q Do --

A Then so those monitoring systems, they have to be tied in with clinical judgment, and you can't just ignore those, and that was clearly there.

Q Do you believe that Dr. Paidipalli ignored the diagnostics?

A He either ignored it or should have or could -- he should have done something about it. So I don't know if he just said I don't care. I can't read his mind. But the data is clearly there.

The end points from making the decision

to extubate that child clearly were not supportive of that care. And a reasonable anesthesiologist given the set of facts for Brett, in his physical condition, that's well-documented by the Pre-Anesthetic Record, clearly support the outcome. But it's an expected outcome. It's not a surprise at all, taking the set of facts and the anesthetic that was delivered to that patient.

Q The decision to extubate a patient and wake them up, is that based solely on what the monitors say?

A No, no. There's a lot of different points. So, you know, the first point is to decide whether or not you're going to do -- especially for ENT surgery, there's, you know, one of the -- probably the single largest complication with T&A's is actually bleeding postoperatively. That's the most common concern.

The second most common concern is loss of airway, which actually bleeding can cause loss of airway for -- what happens is blood gets in your airway and it gets on your vocal cords. And your cord spasms. Children are at high risk for this.

And so the decision point in this is a debated way to do it, and there's actually studies that

look at do you do an awake extubation so you have the child fully awake and they are completely with it and interacting with you, and it's, you know -- or do you keep them deep anesthetized, pull the tube out, and then stay in the room longer, let the gas, inhaled agent, go down enough for them to support and maintain their respirations, and then -- you know.

And sometimes you would even bring that patient to the recovery room in that state and you would stay with them and monitor them, one of -- either the CRNA or the physician would stay with the patient while they were monitored until they, you know, arouse and make sure that they are appropriately monitored.

Both -- both -- both decisions are reasonable choices, and there's actually studies that show the benefits of one and the benefits of the other, and that's a clinical decision that you make.

And I can't argue with that clinical decision, but if you're going to do either one, whatever that choice is, you have to do it in a medically acceptable way, and that medically acceptable way could be done in Nashville, Tennessee or Memphis or Alaska, for that matter, but there are certain physiologic variables about giving anesthetics that don't change.

There's judgment calls and then there's "I'm ignoring the available monitoring I have." And those are two separate points.

Q Do you know what the CRNA that handed the patient off to Nurse Kish informed her about?

MR. LEDBETTER: Object as to form. Also, it's a double question.

BY MR. GILMER

Q Do you have what the -- do you have any idea what the CRNA that transferred the patient to the PACU reported to Nurse Kish?

A I didn't see any documentation of what she did or did not. There was some mention that -- I think in one of the affidavits I saw that the circulating nurse, maybe, brought the patient to PACU, and not Kish, so -- but, I mean -- not Kish, but the -- I can't remember her name, the CRNA -- that one of them brought -- so I'm not aware of the hand-off. And there -- there's no documentation that I could find of what exactly that was.

Q If the patient was delivered to the PACU with supplemental oxygen, would that change your opinions in the case?

A If the patient was delivered -- it would make me think that the patient received oxygen, but it

wouldn't change my opinion to the fact that the patient was extubated at a point when he was having inadequate ventilation to support himself and that the end point of him getting hypercarbic and developing respiratory failure and subsequent hypoxemia were inevitable unless something else was done about it. The point to impact that was in the operating room before he ever left the operating room, so --

Q So the decision -- are you saying that the decision to extubate led to the respiratory failure some ninety minutes later?

A Absolutely, no doubt about it.

Q And there was no -- what clinical indications or monitoring indications do you have from the PACU that the patient was having difficulty ventilating?

A Two. Probably the most important one is tachycardia, which is -- you know, is -- can be caused by hypercarbia. Tachycardia in a infant can be -- or a child; he's not an infant -- or an adult can be caused by a variety of things.

This -- Brett received a medicine called Glycopyrrolate, which does tend to increase your heart rate, and he just had surgery, which are two things that can cause your heart rate to go up. So can

hypercarbia.

So it's hard to differentiate that out. They do not monitor end-tidal CO2 in the PACU routinely, and I didn't see any record that they did it there.

There's some issues with the accuracy of CO2 as measured by me breathing through a mask or a nasal cannula as versus an endotracheal tube as -- which was the measurement that Brett had, because they used a 6.5 endotracheal tube that was cuffed for him, which would make the end-tidal CO2 very accurate. And so they didn't -- you know, once the tube was removed, that's -- you know, we don't have any more data points for that.

The other issue is that Brett clearly had what we call emergence delirium, and that is actually pretty common with kids. That's basically what you and I might say you're awake but you're not cognizant and you're not able to make rational decisions. You'll swing at people. You will often obstruct your airway. You can't control your airway. You can't breathe -- you might breath a little bit, but it's -- you know, we see this in adults all the time.

Children are much more prone. So they're -- the amount of attention you have to pay to

this in a child is dramatically more, especially a twelve-year-old child that weighs 80-something kilograms, who has obstructive sleep apnea, like I said, and is getting his tonsils done. It is dramatically higher.

So when patients -- you know, one of the primary things that, as a pediatric anesthesiologist, you have to rule out is hypoxemia and hypercarbia. I mean that is very clear. That's one of the first things you have to do.

And, you know, oxygen saturation monitors are specific but not very sensitive, and the difference is that they are telling you the saturation of hemoglobin -- of oxygen and hemoglobin. Okay. So if when we talk about -- when we're looking through the labs, we have something called PaO2, which is the partial pressure of oxygen within the blood. Well, that -- there's a -- you know, there's a relationship between the two, and they are not linear. And that's why oxygen saturation monitors are not a -- not a very specific monitor of hypoxemia.

So if your PaO2 is 300, your sats going to be 99 percent. Well, if your lung function is down or you're hypercarbic and you're not ventilating well and your CO2 is up to maybe 100, and that CO2 of 100 is

causing you to get more respiratory depressed and not breathing even more, your PaO2 may be down to 75 or 80, and your saturation will still be 99 percent.

So the monitoring devices that we use have their limitations, and that's an important part of what we do as anesthesiologists is ensuring, in spite of those limitations, that we're making the appropriate assessments of the patient, which includes specifically physical exams.

Q And that is also why it's important for the PACU nurse to monitor the patient carefully?

A Agreed.

Q I want to go through and --

MR. GILMER: Well, how much more have you got?

VIDEOGRAPHER: This would be a good time to take a break.

MR. GILMER: Okay.

VIDEOGRAPHER: I've got about twenty-five minutes, but --

MR. GILMER: Oh, I mean I can keep going. I can keep going for twenty-five minutes, if that's all right. I'll grab the medical record here.

BY MR. GILMER:

Q The Anesthesia Record --

A Yes, sir.

Q I would like for you to go through the Anesthesia Record and explain to me exactly what ...

A Okay. You want me to just go through it, or do you have a specific question you --

Q No, I -- yeah, I would like for you to go through specifically the issues that you've just discussed regarding the hypercarbia.

A So may I share your pen? So as you can see here [indicating], Brett came into the operating room and he was put on nitrous, which is laughing gas and air, 7 liters, amended in 3 liters -- an amendment which is a normal way we induce a child -- and then Sevoflurane, 8 percent. That's the maximum amount of Sevoflurane.

So you're trying to, very quickly, get the child -- but you don't have I.V. access. And then once you get I.V. access, then they gave Robinul, which is a medicine that prevents children from getting their heart rate down a lot in -- so you see that. At the same time, his heart rate, which is this dot here [indicating], kicks up from 80 to 110, which -- the good news about Robinul is it prevents the brachycardia, but it also hides signs of hypercarbia, such as tachycardia, because you don't know what that's

from.

After they got the Sevo- and they got the IV on board, what they did is they gave this Robinul I.V. and lidocaine, which is a local anesthetic that we also use as an induction agent. It makes the Propofol, which is their -- a primary induction agent, not burn as much, but it also has some centrally acting CNS effects, itself. It's 100 milligrams, 200 milligrams.

These are very reasonable, consistent doses. And 100 mcg of Fentanyl, which is a very potent narcotic -- that's about 1.2 per kilo. That's very consistent. And then they give Decadron, which is often given to patients who have the tonsils done, just to decrease swelling.

They gave him another 50 of Fentanyl down here at the very end, which is -- probably caused some of this issue; Zofran, 4 milligrams, which is an anti-medic. LR is a fluid. And so what you --

Q What's the -- stop just there for a second.

A Yep.

Q You said they gave him 50 of Fentanyl later?

A Yeah.

Q And then that's probably what caused --

A That -- that played into it.

Q Okay.

A This is multifactorial.

Q Mm-hmm.

A This is not a single -- you know, there's multiple issues that come into this.

Q All right.

A Notice that the --

Q Let me ask you some specific questions about this.

A Yes, sir.

Q First of all, the initial drug choices: Do you have any criticisms of the drugs themselves or the amounts of drugs that were provided?

A No, sir.

Q Okay.

A My only concern would be using -- some would argue Fentanyl, because of its respiratory depression effects in a patient with sleep apnea -- many people would argue that you get the child completely awake before you give them any pain medicine because what will happen is that this will depress them, especially someone of his size and weight, and especially giving it not here, but back here

[indicating]. Even this 50 mcg could have suppressed his breathing a little bit.

Q Do you believe that that's a deviation from the standard of care?

A I don't think it's a lot of deviation from the standard of care, no.

Q Okay. All right. Continue.

A So when you first see here they have his tidal volumes, TSV tidal volumes and their documented as 446, you know. So Brett is 80-something kilos. We base normal tidal volumes on your ideal weight, which is based upon your height, which -- for him, we'll just say it's about's 70 kilos, give or take a few. That would be about 420 cc's. It would be 6 cc's per kilo. Those are very reasonable tidal volumes.

And you see this 446, 416, 200, 145, 180, so these aren't isolated measurements. And usually, when we document these charts, we don't, like, document the random number. We document what is the trend, because, you know, his heart rate can go around -- his pulse ox might go around. We don't normally document that, especially on a written record.

And at the same time, you see his end-tidal CO2. Where is that at? You know, you see his tidal volumes going down, his respiratory rate

actually going up, which is consistent with someone who is actually getting hypercarbic but doesn't have enough -- they are not exchanging their dead space very well.

So -- and then his CO2, which is -- where is it at? There's his FiO2. That's his saturation. Where is his CO2? I just saw it. Here it is, end-tidal CO2.

And you see this, where it started, what looks to be 41, which is pretty consistent. And I think there was a note about that. You know, a child with sleep apnea, there's going to be a gradient of about 4, 5.

I wouldn't see -- expect a twelve-year-old who didn't have significant right heart failure to have CO2s much higher than this walking around. Otherwise, they would have heart failure, because hypercarbia chronically induces something called cor pulmonale, which the increased resistance in the pulmovasculature actually causes the right heart to fail. And there's symptoms that you see, like edema in your legs and such as that, liver failure, kidney failure.

And then what you see -- and that's a very normal -- so his arterial CO2s really are probably

about 45 here. And you see this gradual increase. Again, this isn't just a random shot. This is -- this is a trend. This is clearly there. And basically, his tidal volumes are getting lower, his CO2 is going up, and his respiratory rate is going up, trying to compensate for that.

That clinical picture is very consistent with a child that's hypoventilating, in that, you know, they -- I think, if you look at the times here, they suction extubated at 10:26. They turned their Sevoflurane off here somewhere between 10:15 and 10:30. They don't specify when. It's in the middle -- they have an "x" here that makes me think it's closer to 10:30.

This child would still have a significant amount of Sevoflurane on board. And the Sevoflurane -- it depresses your respiration and shifts what we call your CO2 respiratory drive curve.

So there's this linear relationship between if your CO2 rate is "x," your ventilatory rate will be a certain number, okay? And what happens is Sevoflurane will shift that number over. You won't breathe the same rate at a higher CO2. You'll be kind of depressed. And the narcotics do the same thing. Volatile anesthetics do it slightly differently.

So what happens is that you get higher CO2s. And that's expected, to have mildly high CO2s, maybe an end-tidal of 45 or so, at the end of an anesthetic, but 56 in a child with sleep apnea is very concerning.

Q Did Brett's breathing conditions prior to surgery, the conditions that he was there to have surgery about --

A Uh-huh.

Q -- contribute to his hypocarbia?

A Absolutely, yeah. So it's well-documented that -- and well-explained that patients who have sleep apnea are at increased risk of just apneic periods, and some of it is anatomy.

And there's really two types of sleep apnea in children. There's Type 1 and Type 2. And Type 1 is thought to be due to, you know, certain things; and Type 2 is thought to be due to certain things. And sometimes with kids who have sleep apnea or syndrome, they may not necessarily be obese.

And even after you resect the tonsils in a child who has had a T&A, they will still have post-resection apneic periods just because their body has been doing it for a while. We don't really know why, but it does that.

Q Okay. What else is significant about the PACU Record?

A And this is the OR Record.

Q I'm sorry, the OR Record.

A Let me look if there's anything else. With the tidal volumes -- I mean his heart rate is up, but that could be from hypercarbia. Robinul in this -- you know, there's a big debate within medicine about do you even give Robinul for a twelve-year-old because of this right here, because it's going to mask your signs a little bit, maybe.

You know some of it, I guess, is the time, you know: "10:26, section and extubated, in PACU ten minutes later." I wonder why ten minutes, you know? Does that mean the report was given at that time? I mean that's probably the paper charts. Was that -- you know, it's -- you're writing it sometimes not as it happens but later. So I don't see anything dramatic.

Those are the big issues right there that really, you know, stand out and jump out at you as the fact that he was still probably asleep when he was extubated and not really fully aroused.

Q Do you know what clinical signs Dr. Paidipalli used to decide to extubate the patient?

A Uh, I don't see any evidence of that. I remember -- I remember in his deposition, he just kept talking about clinical judgment without any, really, explanation of what that was. So no, I don't.

Q What does the standard of care require for a pediatric anesthesiologist extubating a patient? What clinical signs is that -- does that standard require them to consider?

A It sort of depends on if you're doing an awake or a deep extubation. If you're doing an awake extubation, it's reversal, if appropriate, and there's the ability to protect your own airway, follow commands, breathing adequate minimum minute adequate tidal volumes at an adequate rate and be hemodynamically stable.

Q Okay. Do you have any criticisms of the pre-anesthesia evaluation done with this patient?

A I couldn't read it --

Q Okay.

A -- very well. I mean do you have a copy of it? I don't think it's -- you've got the billing form here and you've got the Anesthetic Care Record.

Q Well, based upon your review of the chart, do you have any criticisms of it?

A They noted that he had sleep apnea.

They noted that he snored and had loud gasping respiration, so they were clearly aware of his respiratory history.

Other than that, Dr. Paidipalli's plan, I couldn't actually -- it was uninterpretable. I read -- I thought I could read something, but I couldn't honestly attest to the fact that I understood what his thought processes were going into it.

Q Do you have any criticisms or believe that it was a deviation from the standard of care to put this patient to sleep using general anesthesia?

A No.

Q Would local anesthesia be appropriate to do an adenoidectomy and tonsillectomy?

A I've never seen a local anesthetic done in the United States. And I'm sure they do it in some places where post-op issues are, you know, more of a concern, but I'm not aware that -- of anyone doing it, no.

Q Are you aware of any other way to perform the surgery other than to put the patient to sleep using general anesthetic?

A You can do it under local, but I don't think anyone does that. I think it's usually a general. You don't have to do a tube, and endotracheal

tube. You can do an ILMA, which is a laryngeal mask airway, which is a device that just sits above the glottis. Some centers do that, but I think that the primary way people do a tonsils & adenoid is to put asleep and put a breathing tube in.

Q So the decision to intubate and use a general anesthetic to perform the surgery was in accordance with the standard of care?

A Yes, sir.

Q Okay. The medicines that Dr. Paidipalli chose and the amounts of them were also in accordance with the standard of care?

A Everything -- the little bit -- the Fentanyl, I think you can make an argument that, in his situation, that it may not have been wise, and if you would have given it -- I would have given him a lot of time to make sure any washed out his Sevoflurane. That was about it.

Q Well, do you believe that it was a deviation for him to use it at that point in the case?

A That would probably be a stretch.

Q It would be a stretch to consider it a deviation, right?

A Yes.

Q Okay.

A Because if he's uncomfortable, then he's going to be delirious, too, if he wakes up hurting.

Q Do you have any opinion concerning the documentation that Dr. Paidipalli made?

A This chart is primarily done by the CRNA, and the only thing that he did was this portion right here [indicating] as -- you know, based upon the handwriting, looking at it. I'm not aware of any other documentation that I saw other than the pre-op anesthetic assessment, and that was uninterpretable.

Q Do you have any criticisms of the documentation made by the CRNA on this Anesthesia Record?

A The documentation seems fine. The medical decisions do not.

MR. GILMER: Okay. Let's mark the Anesthesia Record as the next numbered exhibit.

(Anesthesia Record marked as Exhibit No. 7 to this deposition.)

BY MR. GILMER:

Q And, Doctor, for the record, the blue ink that is on here, you just made, correct?

A Yes, sir.

MR. GILMER: Okay. Why don't we take a break?

VIDEOGRAPHER: This is the end of Disc No. 1. The time is 3:07.

(Recess taken from 3:07 to 3:15 p.m.)

VIDEOGRAPHER: This is the beginning of Disc 2 of the deposition of Dr. Jason Kennedy. The time is 3:15. You may begin.

BY MR. GILMER:

Q Doctor, we had just went through the Anesthesia Record and talked about your -- the bases for your opinions. What, in your opinion, did the standard of care require of Dr. Paidipalli to do rather than extubate the patient at 10:26?

A To allow the patient's spontaneous respiratory drive to return to normal and to assist him into that point.

Q And how would he have done that?

A By keeping the breathing tube in and assisting his ventilation via the anesthetic machine as a way you can manually support his breathing, or you can put him back on the ventilator that's incorporated into the anesthetic machine.

Q This use of supplemental oxygen was not sufficient?

A No, because supplemental oxygen can actually kind of hide that hypoc -- low tidal volume

ventilation that you see. It might have prevented him de-saturating, but it wasn't going to prevent his eventual outcome.

Q The -- at the bottom right-hand corner here, it talks about the -- what does this say, "ICU/PACU at 10:35"?

A Yeah. That's either ICU or the Post-Anesthesia Care Unit at 10:35 versus 10:36. I don't know if they were in the unit at 10:35 and did that at 10:36. And these are the vital signs.

Q Okay. And what do -- do the vital signs indicate anything to you?

A Nope.

Q Anything abnormal?

A He's a little tachycardiac, which means he has a fast heart rate at 118. His respiratory rate is 22, which is a little fast. And in someone who was agitated and delirious, it would make me -- you know, were trashing around in the bed or removing things, it would make me very concerned that they are actually hypercarbic.

Q But being -- thrashing around or emerging --

A Moving.

Q -- at that point, that in itself, can't

that make you tachycardiac?

A Yeah. So can the glycopyrrolate, but the combined picture -- so taking one single vital sign out of -- out of context, can get you into trouble. But if you take the totality of the data that's present, it's very clear what happened to him, and this was foreseeable coming out of the operating room.

Q Let's go over your report that you did in the case.

A Yes, sir.

Q That's your copy [indicating], and I'll use his copy. The first paragraphs have to do with your background. Let's see, it shows what you have reviewed. And we've talked about what you've reviewed. Did the photographs of Brett help you form any opinions in the case?

A Yeah, it did.

Q How so?

A The fact that he was in a position that I would not consider consistent with the standard way I would position a post-tonsillectomy patient of Brett's size and body habitus.

Q What did the standard of care require as far as the positioning of the patient?

A You can do it in a lot of different

ways. You could be supine with the head elevated, which according to Kish was a common thing. You could be in what they call the semi-lateral position with your head slightly elevated with the -- basically kind of sleeping on your side to allow some of the secretions to come out. That would be reasonable.

The knee/chest position, being completely prone -- I've seen that, and I've done that before with young babies, young children, but they are so much smaller, and the weight, their total body weight, is less of an issue, laying on their diaphram, as in Brett's case, who was 82-, 81-kilos, not -- I've never done that with an adult before.

Q With -- when you say prone, Brett's face was turned to the side, though, correct?

A As best as I could tell in the picture, he was face down and -- but it was -- I mean it was a picture. And that's -- and that's the best I have. And I think there were statements made by Kish about him being, you know, face into the gurney.

Q And she had the ability to change that position or notify someone about any concerns that she had about that position?

A As did the ENT surgeon, yes.

Q Now, why do you believe that you're

familiar with the standard of care for an anesthesiologist practicing in Memphis, Shelby County, Tennessee, in March of 2012?

A Specific to what? What?

Q Well, specifically with your opinions to this case. Why do you believe that you're familiar with the standard of care from Memphis when you have not practiced there?

A Based upon what Dr. Paidipalli's and Dr. Kish's [sic] statements were, doing what they normally did at the children's hospital, and in line with what is normally practiced for anesthetic practice throughout the rest of the country.

Q Do you believe that the standard of care that you are applying is a national standard of care?

A I think there are certain aspects of it, yes, and some of it regarding, for instance, the administration of oxygen or being in a prone position, I'm basing upon the statements that both the ENT surgeon, the anesthesiologist, and Nurse Kish said what was normal and customary in their practice.

Q And so that would be the same for any anesthesiologist practicing anywhere?

A There might be subtleties about whether or not you give oxygen to patients, but, you know, what

is normal and customary in their practice. You know, kind of doing the same thing in what we normally do is probably the safest way to practice, and if you deviate from that, that's usually where you get into trouble.

So if you bring out every patient prone, then, you know -- or every patient on their side -- but this, you know, by Nurse Kish or Dr. Paidipalli or Dr. -- the ENT surgeon's own statements is that they did not routinely do that, that that was different than what they would normally, routinely do.

Q Getting back to my question about --

A I'm sorry.

Q -- what the standard of care is that you're using in this case, your opinions that you are using in this case, let's agree on a couple of things.

A Yes, sir.

Q Number one, you've never practiced medicine in Memphis, right?

A Agreed, yes, sir.

Q You've practiced medicine in Birmingham and in Nashville; is that right?

A And in Atlanta --

Q And Atlanta, okay.

A -- where I did my fellowship.

Q Okay. And do you believe that the same

standard of the care applies in all four of those cities?

A There are small -- there are aspects that are subtly different, but the general practice of medicine is pretty consistent amongst the issues that I'm bringing up.

Q What are the subtleties that would be different?

A What medicines you might use specifically: Would you use Fentanyl or Morphine? Would you use Dilaudid? Would you use an ILMA. Would you do a deep or an awake anesthetic -- I mean extubation.

Would you do -- what size tube you would use, you know; what your reversal agent might be; if you -- would you use neuromuscular blocking agents; what fluids you might administer, Lactated Ringer's, normal saline, plasmalyte. There's any number of those.

As far as monitoring the patient, those standards are pretty consistent across the country.

Q And would they be the same, say, in St. Louis or Los Angeles?

A Yep.

Q And the standard -- the opinions upon

which you base your understanding of the standard of care has to do with that monitoring that you just discussed that's consistent in all of those cities?

A Yes. If you went outside the United States, they probably don't do capnography because they don't have that technology available, but we have that technology available here in most places in the United States.

Q What -- tell me what you know about Memphis and its medical community.

A I met a couple of good physicians in different meetings, trips through Memphis a couple of times. And that's about it.

Q How many hospitals are in Memphis?

A I don't know the answer to that.

Q Do you know how many beds are available in the hospitals in Memphis?

A No, sir.

Q Do you know which hospital systems are in Memphis?

A I know there's Methodist, and that's about it.

Q Is there a teaching institution in Memphis?

A I think so, but I don't know that for a

fact. I think it's part of the UT network, but I'm not 100 percent certain of that.

Q What's your knowledge of the Methodist Le Bonheur Hospital?

A Other than the records I've reviewed, specifically the Methodist Le Bonheur. That would be it.

Q Do you know which specialties are available there?

A I know some of them, obviously, pediatric ENT.

Q What else?

A But not all of them. I mean, probably, the majority are specialties that you would find at any hospital: Internal medicine, family practice, endocrinology, hepatology, pediatric intensive care medicine -- because he was -- Brett was cared for by Pediatric Neurology.

Q Do you have any first-hand knowledge of any of that?

A Other than the -- reviewing that, what I saw in the depositions and the medical records, no.

Q Other than the depositions and the medical record, you have no other knowledge of the medical community in Memphis, do you?

A No, sir.
Q What is the population of Memphis?
A It's more than Nashville. I think it's about a million.
Q Do you know which hospitals are in the medical district?
A No.
Q How many hospitals are in Nashville?
A How many hospitals in Nashville? Vanderbilt, Centennial, Baptist, those are the only ones I know for a fact are in Nashville.
Q Do you know how many hospital beds are available in Nashville?
A Do not.
Q Do you know what the population here is?
A Less than Memphis.
Q Do you know which specialties Nashville has that Memphis does not?
A No, because I know they do heart transplants out there, from a cardiac standpoint, but other than that, I don't know.
Q So other than your knowledge of what the Nashville standard of care is, you have no independent knowledge of what the standard of care is in Memphis, Shelby County, Tennessee?

MR. LEDBETTER: Object as to form. The witness has already asked and answered this question on this case and as to these issues.
THE WITNESS: So what does that mean?
MR. GILMER: Back to my question -- and I'll ask counsel not to make speaking objections anymore.
BY MR. GILMER:
Q If -- other than the national standard of care that you have discussed earlier, you have no independent knowledge of the standard of care in Memphis, Shelby County, Tennessee, do you?
MR. LEDBETTER: Object as to form.
MR. GILMER: Objection noted.
MR. LEDBETTER: It's a compound question.
THE WITNESS: So ...
BY MR. GILMER:
Q You can answer my question.
A So just repeat it one more time for me.
Q Sure. Other than your knowledge of the national standard of care, you have no independent knowledge of what the standard of care is in Memphis, do you?
A I've never practiced in Memphis, I want

to say.
Q And you have no -- you've had no discussions with any anesthesiologist regarding the standard of care in Memphis, have you?
A I've never practiced in Memphis, Tennessee. I've talked to Memphis anesthesiologists at meetings before.
Q Have you talked about the standard of care, or is it just in passing?
A We talk about medicine practice. We're not talking about golf, usually. We're talking about the practice of anesthesia, usually, when it's an anesthesia meeting.
Q Are you a part of any organization, any organizational committee that develops guidelines and policies and procedures for anesthesiologists?
A No.
Q Let's look at your document here. On the first page, do you see anything on there that you changed from your original report?
A I'm just reading the --
Q Sure.
A Not that I can see.
Q Okay. On page 2 -- and I want to go through these individually. The first one just says

that you reviewed the medical records, and we've already talked about that. Number two, would you read that and then explain your basis for that?
A "Defendants failed to follow the proper standard of care in that they failed to appropriately ensure that Brett was appropriately and safely monitored and assessed in the PACU. There are no records of them assessing the patient in the recovery room until after the initiation of the code, a period of about an hour.
"Both physician agreed that such monitoring and assessment was necessary, but neither assured nor verified the proper positioning, proper supplemental oxygen, or proper monitoring occurred or was provided.
Anesthesiologist supervision was needed until the patient, Brett Lovelace, was awake and maintaining his own airway." Continue?
Q No. We'll stop there. First of all, there's a footnote, No. 2 there. Is that a -- it says "See Clinical Practice Guideline: Tonsillectomy in Children." And that's about "Baugh, et al., Otolaryngology."
A Yes.
Q Is that something that you reviewed

prior to forming your opinions in the case?
A It is something I reviewed prior to forming my opinions, yes.
Q And that is in addition to the other texts that we discussed earlier?
A Yes. So whatever I footnoted in this would be in addition to that.
Q Why did you cite specifically to that particular publication there?
A Because I thought it was relevant to the discussion, pertinent to the information provided.
Q What did you -- what do you believe the standard of care required Dr. Paidipalli to have done with respect to the supervision of the patient?
A So to have been present during emergence, when the decision was made to extubate the patient, and to make the decision to extubate him; to either accompany him to the recovery room or to ensure an appropriately trained person did that, specifically a CRN, a licensed CRNA; to ensure that the nurse in the recovery room was appropriately trained and educated and was made aware of whatever issues that were pertinent to this patient; to check on the patient at some regularly stated interval to ensure that he was cared for appropriately and, specifically, to any

issues that he had; and make sure that the nurse was aware of his specific issues that would impact his monitoring.
Q Based on the standard of care that you're using, what -- what time frame should Dr. Paidipalli have checked on the patient?
A I would have immediately either accompanied this patient to the PACU -- I would have extubated the patient, but if -- after extubation, based upon his body size and habitus, I would have checked on him within ten or fifteen minutes.
Q And when you say "I would have," you agree with me that what you do does not establish a standard of care, right?
A I think a reasonably prudent anesthesiologist, with an 82-kilo twelve-year-old boy with sleep apnea, with his tonsils out, would check on a patient. I think any reasonable anesthesiologist, be they a pediatric anesthesiologist or an adult -- would do that for a child that had recent airway surgery, yes.
Q When you transfer a patient to PACU, do you accompany each and every patient that you do?
A I either accompany every single patient that I take care of or I immediately see them within

ten or fifteen minutes.
Q Each and every one?
A Each and every single one.
Q And do you rely on CRNAs to transport patients sometimes from the operating room to the PACU?
A I surely do.
Q Do you ever admit -- I know that you said that you do some practice in the ICU. Do you admit patients from the operating room directly into the ICU after extubation like this? Did, in other words -- wait. That's a bad question.
A Yes.
Q In other words, do you have any criticisms in this case about Dr. Paidipalli's decision to admit this patient to the PACU versus the ICU?
A A typical tonsil & adenoid that had been extubated with appropriately tidal volumes, minimal minute ventilation, I would have no problem going to a PACU. A child that's clearly hypoventilating and not responsive appropriately, I would consider sending to the ICU.
Q What would have been different with the monitoring that would be in an ICU versus in a PACU?
A A PACU is really an ICU. I mean it's an intensive care unit, for all -- for all purposes.

Q One-on-one care?
A One-on-one or one-on-two care.
Q Okay.
A So, yeah, I mean there is a high level of care there. The difference, probably, that is at -- in the ICUs, that there's going to be a physician dedicated to that ICU that doesn't leave and is working in the other operating rooms and doesn't have responsibilities there, like I'm sure Dr. Paidipalli had.
Q Do you believe that any of the physicians or CRNAs would not have been available had they been summoned by Nurse Kish?
A I have no data to make a decision on that.
Q Do you have any reason to believe that they would not have been available had she called for them?
A That would be supposition on my part.
Q Well, when the code occurred, how quickly was Dr. Paidipalli --
A It sounds like immediate.
Q And in this case, Brett had one-on-one care in the PACU from Nurse Kish, did he not?
A He did for about ninety minutes.

Q Let's go to your --
A Statement?
Q -- third statement.
A Third?
Q Yes, please.
A Okay. "Defendants failed to follow the proper standard of care in that they failed to appropriately ensure that Brett had fully emerged from and recovered appropriately from the anesthetic prior to the removal of the endotracheal tube. Brett's documented tidal volumes prior to extubation were a mere 145 to 180 cc's. This is a very small tidal volume for an 81-kilogram child.

"This, combined with documented hypercarbia, makes it unlikely that he was ventilating adequately at the time of extubation. Brett's high end-tidal CO2 level of 56 torr, as recorded on the Anesthetic Record, support the assertion that appropriate assessment and attention would have prevented the subsequent hypoxemia and acidosis."

Q That last sentence is what I'm hung on "... support the assertion that appropriate assessment and attention would have prevented his subsequent hypoxemia and acidosis." How long does it take for a patient in this -- such as this, to have brain damage

from a hypoxic event?
A So a lot of that depends on -- it depends on multiple factors. So when looking at the brain being hypoxemic, it's really dependent upon what we call DO2, "delivery of oxygen" to the brain.

And DO2 is dependent upon two things; and that's the content of oxygen within the blood and the cardiac output. And it's also -- for the brain, it's dependent upon the amount of vasoconstriction. Okay? And high levels of CO2 initially cause vasodilation in cerebral vasculatures, but eventually will cause vasoconstriction.

The primary issue would be the amount of oxygen in his blood and the -- his cardiac output. So the issue is that, you know, that could have progressed over time. He was -- so the answer to your question: It's variable. Like if I pre-oxygenated you right now and made you all of a sudden apneic, you can last about eight or ten minutes if you were apneic, meaning not breathing at all, and I had filled your lungs up with oxygen.

And Brett was on 100 percent oxygen, as documented, so his lungs were probably filled with oxygen, though he wasn't ventilating well, which is really the removal of CO2.

He was still making some respiratory effort. He was still having some minimal gas exchange, not enough to keep his CO2 down. And so hypercarbia -- that could have taken quite a while.

So it's well within the realm of understanding that this started here [indicating], and if you look at his first gas, he had a PO2 in excess of -- I mean a Pc O2 in excess of 100, that this was a continuous, gradual decline that started in the OR.

Q Do you believe -- this last sentence here indicates to me that you are discounting anything that occurred in the PACU, as far as the end result in this case. Is that accurate?
A No, I'm not. No, that's not an accurate statement.
Q Okay. So I'll tell you what, let's look at the PACU Record, if we can.
A Sure.
Q Here is a copy of the record you can use. If you would, turn to -- for instance, there's O2 sats. Let's look at his vital signs while he's in the recovery room. And I don't have it premarked. We're going to have to both find it.
A Okay.

Q Have you found his vitals from when he arrived in the PACU?
A No. I'm looking. I mean the first of the vitals would have been on that PACU, on the Anesthetic Care Record.
Q Okay.
A But subsequent vital signs are somewhere else. And I remember seeing them. I'm just trying to find them. Here they are. But the chart is not very helpful in the order in which they order things.

MR. GILMER: Tell you what, why don't we save the tape. Why don't we go off the tape real quick and let us find this.

VIDEOGRAPHER: We're going off the record. The time is 3:43.

(Recess taken.)

VIDEOGRAPHER: We're back on the record. The time is 3:46.

BY MR. GILMER:

Q At what point in the PACU did his vital signs change that gave you any indication that the patient was in distress?
A I'd have to review it.
Q Do you remember when his blood pressure dropped?

A I don't recall the exact time. I'd have to see that chart.

Q According to my notes, it was at 11:34.

A Then I would go with that.

Q Which is about thirty minute before Nurse Kish called anyone. What does a blood pressure of 84/42 indicate to you?

A It can mean a lot of different things. It could indicate that somebody's very sleepy and doesn't have enough intrinsic abionergy tone. It could mean that he's hypovolemic. For, like a patient such as Brett, who had tonsils done, that he had bled, an isolated blood pressure, out of context with the rest of it, doesn't mean a lot.

I think he recovered his blood pressure immediately, with no interventions by her, if I recall. And that -- so that isolated single blood pressure in a twelve-year-old child is really not terribly concerning.

Q If there had been a decline in his blood pressure over the course of the time -- see: At 10:49, blood pressure is 129/63 with a pulse of 120.

A Okay.

Q A respiratory rate of 24 and O2 sats of 100 percent. At 11:03, blood pressure of 118/56, pulse

of 122, respirations of 24. Are there any issues with those vital signs that you've seen?

A No, sir.

Q All right. At 11:20 -- so twenty minutes later, we have a BP of 106/53, with a pulse of 118, and respiratory rate of 24.

A You have the one issue that -- probably, with the previous one, the previous set of vital signs, and these vital signs, is that his heart rate continues to be high. Now, the glycopyrrolate explains that when he was in the operating room and immediately in the recovery area, probably in the first thirty minutes, maybe thirty-five or forty-five minutes, but to have this persistent low-grade tachycardia, which was not consistent with his age or his baseline heart rate, does raise concern that there's something else going on.

Q Did the standard care require Nurse Kish to notify someone of that continued tachycardia?

A I would think so, that I would let somebody know. The isolated blood pressure alone wouldn't do it, but you know, it's not far outside of reasonable to have a child that's a little tachycardiac, and that is just a little tachycardiac. It does kind of raise some red flags.

Q Fourteen minutes later, his blood pressure dropped to 84/42 with a continued pulse of 114 and a respiratory rate of 24. His O2 sats was noted as 99 percent on room air. So that change in those fourteen minutes, does that indicate anything to you?

A It could, but again, if I were caring for that patient or I would -- if I had a nurse who was caring for that patient, I would expect them to re-cycle the blood pressure, reassess the patient, and then make a decision whether or not to do something at that point.

Q And that's what the standard of care requires?

A That's what the standard of care would require.

Q Do you agree with Nurse Kish when she testified that she should have notified somebody at 11:34 with this change in blood pressure.

MR. LEDBETTER: Object. Go on.

THE WITNESS: Do I agree that she should -- you know, trying to go back and read her mind is difficult. Like I said, that isolated blood pressure, by itself, does not portend, per se, an issue.

It could be the -- you know, it could be

caused by a lot of different things. Is her regret and her statement based upon the fact that she has a twelve-year-old child that died and that she's looking for some explanation or something she should have done different, maybe. I don't know.

I can't read her mind. But that alone -- and there's other things, you know, that it could be. It could be significant hypercarbia. It could be, you know, the patient's bled out, so ...

Q Well, we know he didn't bleed out, right?

A Exactly.

Q And --

A After the fact.

Q Do you believe that there was a point in time where Brett was beyond being saved?

A There likely was, but that point, I don't think you can determine from the available records other than --

Q Do you believe that that point fell before 11:59?

A Did that point fall before 11:59? It clearly had to fall before 11:59 and sometime after he was anesthetized.

Q But you have no opinion as to at what

point?
A That would be conjecture on my part.
Q Okay. If you would, go back to your --
A Yes, sir.
Q -- statements there.
A Statement 4?
Q Yes, sir.
A As read, "The defendant failed to follow standards of care in that they failed to ensure adequate ventilatory support in a patient who is obese, with sleep apnea. Brett's initial arterial blood gas, his ABG, is recorded as a pH of 6.70, a partial pressure of CO2 of 96, a partial pressure of oxygen of 502, a bicarbonate of 12.

"This ABG was performed after at least ten minutes of positive pressure ventilation, since per the code note, he is intubated -- re-intubated at 12:04, and the first blood gas was reported to be at 12:18.

"Therefore, the initial CO2 was likely much higher. There is a sample that is reported to be a sample venous that has a pH of 6.59, a CO2 of greater than 130," which is unmeasurable.

"This is an incredible amount of hypercarbia resulting from a likely prolonged period of

hypoventilation as consistent with a patient who was extubated in a non-fully awakened state, in deep extubation, and without appropriate insurance that he was maintaining adequate respiratory rate and tidal volumes.

"This was a clear breach of the standard of care in any patient who had undergone a general anesthetic, and especially true in an obese child with sleep-deprived breathing who undergoes a tonsillectomy."
Q Let's go through that slowly. There's a lot of information contained in there. When is the initial ABG recorded?
A I think there's initial venous blood gas, but the initial arterial blood gas, I think, was twelve or thirteen minutes after he was intubated. I think it was at 12:18. I think he was intubated at 12:04.
Q Okay.
A And that timing on the blood gas is the time it was ran, not the time it was drawn in those institutions.
Q Was it -- do we know when it was drawn?
A I saw -- found no documented evidence of when it was drawn. And I don't know if that was a

bedside arterial blood gas monitor or something that would be sent to a lab and hand-delivered. I have no idea. It's conjecture on my part.
Q When you say "This is an incredible amount of hypercarbia resulting likely -- resulting likely a prolonged period of hypoventilation," how long was that prolonged period?
A So you can -- so if you're apneic -- that means not breathing at all and you have no -- you're not ventilating in any way, shape, or form -- your CO2 will go up. I think it's 8 in the first minute and 4 for every minute after that.

So you can say that Brett wouldn't have went up greater than that, because he still was breathing but hypoventilating in the recovery room and in the operating room. So it could have been going on -- I mean I think that the -- from what we saw, the evidence is clear that he was hypoventilating from the time he left the operating room.
Q Is there any testing that would have told us whether or not he was adequately breathing when he left the operating room?
A They could have done a arterial blood gas which would have been a needle stick to draw out blood from his [inaudible] arteries. You could have

used an end-tidal CO2 to give an estimation of what it was.

And for a patient that arrived in an agitated, delirious state, with difficulty in maintaining pulse oximetry on him and difficulty to arouse, I think a reasonable physician in the same situation would further assess him, but he or she would have to have been present if they decided to do that.
Q Is a CRNA adequate to assess a patient upon arrival to the PACU?
A Should be, yes, sir.
Q You use CRNAs?
A I do. I still supervise her care, which means I'm responsible for what they do, and I still am sometimes there. I mean their level of training is not the same as a physician, and ultimately, I'm responsible for what they do or don't do, so I always go back and reassess the patient. It's a safety net.
Q And when you're -- you supervise CRNAs that -- do they put patients to sleep?
A Not without me present, and they don't extubate without me present.
Q Let's look at No. 5.
A Yes, sir. "Defendants failed to follow the proper standard of care in that they failed to

appropriately ensure that Brett had adequate oxygen supplementation in the post-anesthesia care unit. Defendants failed to reaffirm airway patency and adequacy of breathing.

"Defendants should have continued delivery of oxygen by mask to Brett Lovelace until his recovery was complete. Further Defendants -- further, Defendants failed to maintain airway patency with simple airway maneuvers or oro-nasopharyngeal airway until the patient was fully awake. Neither Defendants could explain these lapses, but both agree that such steps were required and standard."

Q So you -- do you believe that an oral airway was necessary? Is that what you're saying?

A If he was obstructing at the time.

Q Do we know that he was obstructing at any time?

A He was reported to be snoring, which snoring respirations, by definition, are obstruction.

Q He had a history of snoring, did he not?

A Uh-huh.

Q Is that a yes?

A Yes, sir. I'm sorry.

Q And using an oral airway would have only agitated the patient further, wouldn't it?

A We would not have put an oral airway in. I would -- I might have put a nasopharyngeal airway, which is a lot less inducing of laryngospasm. It does tend to cause patients to have a little bit more arousal, which would wake them up, but it would maintain his airway.

It wouldn't have changed his tidal volumes at all because Brett was -- even though he was obstructing, he was still moving air and needed to have his ventilatory support. And you see that in his anesthetic record. He had an endotracheal tube in his diaphragm -- your diaphragm is your primary muscle of breathing -- was weakened by the anesthetic.

We know that it -- it's just that curve that we talked about earlier. And I'm not certain even a nasopharyngeal would have changed the course of action.

Q If oxygen was delivered by mask to Brett, would that have changed your opinions in any shape or form as far as once he was in the PACU?

A If -- I think a reasonable physician faced with the same patient would have administered oxygen and then supplemented his ventilatory status with mask ventilation.

Q What is blow-by ventilation?

A Blow-by oxygen is a situation in which you don't have very tight control of the concentration of oxygen that the patient inhales.

So usually for pediatric patients, they will take corrugated oxygen tubing or a tent and put it by the patient -- which you don't really know what percentage of oxygen the patient is actually seeing.

It could be, you know, a lower percentage, you know, 25 or 30 percent, or it could be as high as 50 or 60 percent, but usually not much higher than that.

Q Is that a deviation from the standard of care to use the blow-by oxygen?

A Blow-by is commonly used in children once they ensure that their airway is adequately opened and that they are adequately ventilating, yeah.

Q What do you believe that -- in your opinion, should supplemental oxygen have been administered to Brett the entirety of the time that he was in the PACU?

A I think, based upon current standards of care, national recommendations, and guidelines, in my opinion as a physician, taking care of a patient such as Brett, who is obese, with sleep apnea documented, and having airway surgery -- I think it was appropriate

for him to have oxygen for the duration of his event until he was fully awake and conversant.

Q If he was, in fact, breathing on his own and had a -- had an O2 sats of 99 percent, what would the supplemental oxygen have done for him?

A If he was not conversant -- again, it goes back to your question to how long would it take him to get hypoxia. It gives you more time. It gives you some room to prevent him from getting hypoxemic.

You know, in Brett's situation, he was so hypercarbic that his respiratory drive wasn't going to change until he was assisted. He had to get some of the CO2 off.

So would have the oxygen changed his eventually -- he would have eventually stopped breathing altogether. He would -- or had a cardiac event even if supplemental oxygen was given.

So really the issue goes back to his minimum minute ventilation. Oxygenation would have given you a buffer. It would have been within, you know, the standard of care of what I would have done and what a -- any reasonably prudent physician, especially an anesthesiologist, would have done. It would have been the first thing I would have done.

Q Was Dr. Paidipalli reasonable to --

reasonable to rely on the PACU nurse to continue the use of supplemental oxygen?

A I think I would have expected her to do it, but then again, as an anesthesiologist, I'm supervising her care, and sometimes the nurses make decisions that I do not agree with. Sometimes my CRNAs make [coughs] -- excuse me -- decisions I don't agree with, and I rectify that situation. And the only way to do that is to be present.

Q In your -- what does the standard of care require as far as being present? It sounds to me like you're expecting the physician to be bedside the entire time that the patient is in the PACU in case somebody does something that doesn't live up to your standards.

A So what's your question?

Q So what does the standard of care require as far as the length of time that the anesthesiologist assesses and monitors the patient in the PACU?

A Until -- I mean each individual patient is different, and I'm not asserting that the anesthesiologist stay with the patient at bedside, but he ensures that someone who is capable and taking care of the patient is doing that appropriately.

minutes in the recovery room with a child that had an obstructive sleep apnea and that was 86 kilos. So I don't know where he was at, but he obviously did not assess the patient as per his own assertion and the nurse's assertion. So that --

Q But you said that the standard requires for the physician to be immediately available. What does that mean to you?

A So to be present during induction emergence and all other indicated procedures. So transferring the patient over, that's indicated by the physician, and there's a fair amount of discretion that's allowed for each physician.

What exactly is "immediately available," you know, there's no hard definition for that. It wouldn't mean being at home or being in the building or being three stories up. It's being able to respond usually within two minutes.

Q As an attending physician who supervises residents, you often rely on your residents to do procedures that you're not present in the room for, correct?

A They don't usually do procedures without me in the room. They might. They are obviously anesthetizing the patient while I'm not there, but any

So in the construct of that, if I'm anesthetizing a patient, I might put them to sleep but not intubate them. And I might walk out, away, but I'm ensuring and supervising that the nurse-anesthetist was doing the right thing before I walk out and, again, I'm making certain I took care of the patient. And the recovery room is having the same thing done.

And so it doesn't require my immediate presence at the bedside for the entirety, but it actually does require me to -- at some point in time, to assess the patient, make some decisions about the patient, and interact with the nurse or CRNA or whoever it might be, in making some decision. And you can't supervise if you're not physically present.

That's why it is part of the recommended -- I mean that's part of the standard -- the standard of care. That's what the CMS requires in order, you know, to have reasonable -- it requires the supervision -- for an anesthesiologist, it's to be immediately available and present during all -- during induction emergence, and all other indicated procedures.

Q And do you believe that Dr. Paidipalli was not immediately available?

A He didn't see the patient for ninety

procedure, I supervise personally, and I'm personally present and supervising them doing it.

Q But when they anesthetize the patient, what does the standard of care require for you personally? Do you have to be in the room with them?

A Uh-uh, no, sir.

Q What does it require of you, to be immediately available?

A Yeah. So the exact attestation is, you know, present during -- present during induction emergence and all other indicated procedures. So what's indicated for an otherwise healthy adult or child that's undergoing a general anesthetic is going to be different than an 82-kilo, twelve- -- you know, twelve-year-old that's got obstructive sleep apnea.

I tailor my care for that patient, versus an otherwise healthy 12-year-old that doesn't have sleep apnea having finger surgery done. I -- you know, that's a judgment decision. And there's clearly that, but what a reasonably prudent anesthesiologist would do in that, you know, situation, you know, are going to be two different things, versus what they would do for a -- you know, for a knee surgery or something that doesn't have the same risk that Brett brought to the table.

Q Are those all of your opinions concerning Dr. Paidipalli's care in the case?
A Are those -- are these all of my opinions?
Q Well, I mean have we discussed all -- it looks to me like the -- well, the next few refer to -- well, we'll keep going through these. I'll go through them. Number 7 -- what does No. 7 say?
A The --
MR. LEDBETTER: Have you done Number 6?
MR. GILMER: Yes.
MR. LEDBETTER: Okay.
MR. GILMER: Oh, no, I have not done No. 6.
BY MR. GILMER:
Q Let's go back. Number 6.
A "Defendant failed to follow the proper standard of care in that they failed to appropriately ensure that Brett was appropriately monitored in the Post-Anesthesia Care Unit. A patient in the prone or knee/chest position is difficult to monitor and ensure adequate oxygenation.
"Dr. Paidipalli did not attend the patient in the PACU, reportedly and admittedly, and Dr. Clemons did nothing to correct Brett Lovelace's

position when he saw him prone and on his face without oxygen support.
"Placing Brett Lovelace in a left lateral or semi-prone (tonsil position) slightly head-down, and with a pillow under his chest to allow secretions and blood to drain, was necessary, as well known, but not done here, which was a failure to follow the pertinent standards of care."
And I refer to the Guidelines of the Difficult Airway Society for the Management of Tracheal Extubation.
Q So elaborate on what criticisms you have concerning the positioning in this case.
A The knee/chest position, it would not be a typical position that we would -- would place a patient in after any surgery, but specifically an airway-type surgery of a patient Brett's size.
Q What if the patient moved to that position as a comfort position?
A You would assess the patient, make sure that he wasn't just having postoperative delirium, because in that situation, he or she might do something that may not be necessarily in their best interest.
Just because they move in that position doesn't necessarily mean you should allow them to stay

in that position. So assess their airway, assess their ventilatory rate and status and then make a decision from there of whether or not to move them, but more than likely, I would have moved them into a more lateral position or at least attempted to do so.
Q But the decision to allow the patient to be in a comfort position if he was -- had an adequate airway was something that the physicians were allowed to exercise their clinical judgment in under the standard of care, right?
MR. LEDBETTER: Object to the form.
THE WITNESS: So you're asking me -- again, just restate it, please.
BY MR. GILMER:
Q So the -- if the patient moved into this comfort position that he was in in the PACU and he had adequate ventilation, was adequately ventilating and had an adequate airway, was the decision to allow him to remain in that position a deviation from the standard of care?
MR. LEDBETTER: Object. There's no evidence that he had an adequate airway.
THE WITNESS: If the physicians who had assessed the patient had assessed first his adequacy of ventilation and respiration and had done that first,

that would have been a reasonable course of action, but in the absence of those things, it is not a reasonable course of action.
BY MR. GILMER:
Q Now, the position that Brett was in was a position that allowed for the blood and secretions to drain from his throat in the event that -- since he was a post-adenoidectomy/tonsillectomy patient, right?
A Yes, sir.
Q And that's something that's important with patients who have just had throat surgery?
A That is true. The drainage of blood and secretions away from their larynx would be very important.
Q Because you were explaining earlier that those secretions can cause laryngeus spasm and --
A Yes.
Q Okay. And with a laryngeus spasm, then the patient's airway would be completely blocked?
A Yes.
Q And if the patient were in a lateral position -- well, what position would you believe the standard of care required for him to be in?
A I think there are several different options that you can do. You can do a lateral

position. There's a tonsil position; basically anything that allows him to support his airway but acts to allow secretions to drain out of his mouth.

Now, once he was more awake and talking and conversant and clearly interacting, for him to sit up -- but to be in the knee/chest position would not be consistent with the standard of care for him, especially in the absence of adequate monitoring.

Q When you say, "in the absence of adequate monitoring," what do you mean by that?

A Well, without the ability to assess his ventilatory status, of what his tidal volumes were, or neurologically, just waking him up and doing a neural exam; for instance, having him talk to you.

Q Is that -- I believe that Nurse Kish did an assessment throughout her care of the patient in the PACU that did assess his neurological status, did she not?

A Uh-huh [affirmative].

Q Is that a yes?

A Yes, sir. I'm sorry.

Q And do you have any criticisms of her assessments of that neurological test?

A Do I have any criticisms of her assessment? I think she attested to the fact that that

assessment was not an accurate reflection of the child's situation.

Q And had she adequately complied with the standard of care and appropriately assessed his neurological status, the outcome in this case would have been different, right?

MR. LEDBETTER: Object as to form, compound.

THE WITNESS: I don't know. It depends on when she actually adequately assessed the patient. But he was clearly hypercarbic and not ventilating adequately when he left the PACU.

BY MR. GILMER:

Q But if she had not false-charted that he was -- had an adequate neurological status, then perhaps she would have known to notify the physicians that there may be a problem, right?

MR. LEDBETTER: Object. It's conjecture.

THE WITNESS: I mean could have her actions changed the course? Yes. Could Dr. Clemons, when he came by to evaluate the patient, actually taken responsibility as a physician who's caring for the patient, in the sense that he operated on him, on this boy, just taken a moment to assess him, that would have

changed it.

Could have Paidipalli coming by 45 minutes earlier have changed the outcome? Possibly.

Again, I -- those are all retrospective conjectures that I can't answer to, but they're, you know, within the realm of possibility.

BY MR. GILMER:

Q Because you can't say to a reasonable degree of medical certainty that had Dr. Paidipalli come by to see the patient that it would have made a difference in the outcome in this case, can you?

A Well, he had a CO2 of -- arterial CO2 of 60 when he left the room. I could say with a reasonable degree of certainty that having checked on him earlier and done an appropriate assessment early in the child's care -- that he probably would have had a different outcome.

Q How would he have checked his CO2 in the PACU?

A His primary method of assessing that would have been just assessing his neurologic status, and when he wouldn't wake up appropriately or follow commands, that would have led a reasonably prudent physician to then do further tests such as either an arterial blood gas or just do something as simple as

mask-ventilating Brett, which would have been very simple to do.

Q And if Nurse Kish had notified the physicians that he may not have had an adequate neurological status, then they would have had the opportunity to do those things, correct?

A Yes, sir.

Q Now, when Dr. Clemons came by to see the patient, how do you know that he did not assess the patient's condition at that time?

A I saw no documentation. Other than that, it would be conjecture.

Q So do you believe that he did not assess the patient because he didn't document it?

A What we -- our documentation, a mere chart is our documentation of what we did or didn't do. There's no note or anybody's affidavit that they assessed the patient, including Clemons, that he did a neurologic exam or an airway exam at the time. I didn't see it.

And a physician, regardless of their specialty, would -- in having assessed that patient, could have and should have done something at that point.

Q Do you believe that just because it was

documented -- it wasn't documented, that means it wasn't done?

A Not true, but there's multiple locations where it says nothing to the effect of Dr. Clemons -- including his own affidavit.

Q And we do know that the documentation that Nurse Kish put in the chart was not accurate, though, right?

A Yes, sir, we do.

Q Now, have we talked about all of the opinions that you have concerning the positioning in the case?

A I think so.

Q Or would you like to elaborate on those any further?

A I think so. If you have any other specific questions, I will be happy to answer them, but I can't think of anything else right now.

Q And you're basing your opinion that he was -- or you're basing your opinion about the positioning on an assumption that he was in the knee/chest position the entire time that he was in the PACU?

A On the affidavits and the picture that were shown to me.

Q Okay. Do you know at what point in time those pictures were taken?

A I don't remember seeing a time stamp on them. I remember seeing some that were pre-op, with Brett obviously talking to what appeared to be different physicians -- I assume, Paidipalli and maybe the ENT surgeon -- that weren't identified that were clearly in pre-op.

And then there were pictures clearly post-op, but from a timing standpoint -- and there were some pictures after the code was called when he was in the ICU, but I don't remember seeing any time stamp on them.

Q Number 7.

A Yes, sir. As read, "The ENT surgeon failed to follow standards of care in that he failed to appropriately care for and recognize Brett was not fully awakened from anesthesia. He also failed to appropriately intervene by his lack of any personal action in the care of Brett or by not calling for an appropriate, trained anesthesiologist to ensure that Brett was not oxygenated -- or was oxygenating and ventilating appropriately. An ENT surgeon routinely cares for such patients and should have known to intervene at that time he saw Brett in the PACU."

Q How are you familiar with the standard of care for an ENT surgeon?

A I'm discussing the standard of care of a physician. And an ENT surgeon is an airway surgeon. By definition, he operates in the airway and around the airway.

If we have a problem and we can't intubate someone, we call an ENT surgeon to trach them. So I would say an ENT surgeon is pretty familiar with airway management.

And I can't comment at his surgical standards of care or what he did during any surgery, but the medical management decisions -- that would be consistent with any physician but also any physician that cared for patients who had airway surgery. So this would be similar to what an anesthesiologist would be expected to do.

Q Number 8?

A Yes, sir. "The ENT surgeon failed to follow standards of care in that he failed to intervene in Brett's poor position for a patient who was at high risk of respiratory compromise. By documentation, he saw Brett in the PACU in the knee/chest prone position prior to his arrest, and did not act appropriately to correct the situation."

Q What do you believe the standard of care required of Dr. Clemons at that point?

A Any prudent physician would have immediately corrected the situation and assessed him neurologically, see if he was awake, if his airway was actually opening, because you can be breathing but not moving adequate ventilation -- as we've talked about at great length, with Brett -- and called for an anesthesiologist to immediately come to assess the patient.

And have I had that happen with me? Yes, I've had a surgeon who stopped by to see a patient and called for me to come and evaluate the patient. And I would expect that out of any physician. It could be a family practice doctor. It could be a pathologist, for that matter. This is very simple and fundamental.

Q Just like you would expect the nurse caring for the patient in the PACU to call you if they had a question --

A I would.

Q -- or a concern?

A Or a concern. But with a higher expectation for a physician, especially an airway surgeon such as an ENT. I would have an even higher

level of expectation for that.

Q Number 9?

A Number 9. As read, "Neither physician appropriately followed up on the possibility of the most likely anesthetic complication and cause of death in patients undergoing a -- tonsils & adenoids -- bleeding or loss of airway. Neither arranged for adequate follow-up and evaluation by themselves, a CRNA, or the nursing staff.

The suggestion that clinical judgment is appropriate for post-anesthetic care in this case is analogous to the judgment that a pilot uses when operating an airplane; however, the judgment of a physician is also based upon instrumentation similar to that provide objective information and data to a pilot.

For example, in a storm, a pilot must disregard his physical senses and use the instruments to appropriately fly the airplane. By analogy, the anesthesiologist, like the pilot, has to have an objective sense of the standard physiology variables in order to 'land the plane' or bring the patient safely out of anesthetic -- anesthesia.

"In this case, clinical judgment is not a proper substitute for failure to pay attention to the details and condition of a patient, and to use

customary and accepted safeguards."

Q Well, clinical judgment, in and of itself, requires you to pay attention to the details, does it not? Does that not play into what clinical judgment is?

A I can have a plumber that has really good judgment, but if he's not paying -- if he doesn't understand what he's doing --

So a bedside nurse, for instance, Nurse Kish, might have good judgment or might have poor judgment, but she's limited by the level of her education and what she does and doesn't know. An anesthesiologist has a different expectation.

And you're correct in that if you're not paying attention to the documented numbers on your anesthetic record that are clearly there in the course of action of Brett, then yes, you can have judgment outside of data points. So to go on your gut -- which by reading Dr. Paidipalli's statement, would seem that he went on no other objective data and disregarded the other pieces of evidence, the other instruments that he had to fly the airplane, to land the patient, to get Brett home safely.

Q What experience did Dr. Paidipalli have in taking care of patients such as Brett?

A I don't know Dr. Paidipalli's specific experiences.

Q Do you know if he's been practicing medicine? Do you know when he began practicing anesthesia?

A I remember reading it, but I don't remember -- it's been probably for greater than twenty years, I guess. I don't know the exact date.

Q Do you know how long he had cared for patients at Le Bonheur?

A Again, in excess of ten or fifteen years, but I don't know how long. I remember seeing it. I guess an analogy to that is just because you've been doing it a long time doesn't mean you're doing it right.

Q Sure, but it certainly increases your knowledge base in order for you to exercise your clinical judgment, does it not?

A It certainly increases -- it allows the possibility if you're -- if you're reassessing what you're doing. But just because you've been doing it a long time does not increase your likelihood necessarily of doing it safely, per se. That alone -- you can't say that just because someone has been doing it twenty years, that they are the authoritative expert on

something or that you have to only rely on their judgment.

An experienced physician will use the available data he has and rely more on that, because they're aware that they can be blindsided or misguided by their clinical gut feeling, such as, obviously, Dr. Paidipalli -- happened to Dr. Paidipalli on this situation.

Q Well, an experienced physician, such as Dr. Paidipalli, would have a knowledge base based upon his own training and experiences with other patients beyond that of an anesthesiologist who had only been practicing for four years, correct?

MR. LEDBETTER: Object as to form.

THE WITNESS: So what is your question?

BY MR. GILMER:

Q My question was an experienced physician has a knowledge base that is greater than a -- a young physician. I'm not using you. I don't mean to put you into --

A That's fine.

Q But what I'm -- my question is that over time --

A Yeah.

Q -- do you agree me that one's knowledge

base becomes greater due to the experiences that they have had in taking care of patients?

MR. LEDBETTER: Object as to form, and it's been asked and answered before.

THE WITNESS: I think there is a great to lay a lot of data, a lot of -- to give someone the benefit of the doubt just because they have been doing it for a long time because -- I make, kind of, a lot of analogies for you, but it tends to be that young physicians tend to be very attentive.

And frequently what -- there's something called the ASA Closed Claims Database, and they have actually studied this. So it's actually -- so frequently, older physicians are more likely to make errors in judgment such as Dr. Paidipalli made in regards to using their clinical judgment and their gut over the available data, and they are actually more likely to make those kind of mistakes than a young --

Q What study is that?

A It's a review of the Closed Claims Database.

Q And is that --

A It's openly available.

Q It is?

A Yeah.

Q Okay. And is that something you used to formulate your opinions in this case?

A I wasn't making my opinions about Dr. Paidipalli's daily interaction, because all I had was the data in front of me. It was obvious that his judgment to allow this child to be extubated at the time was not accurate.

Q What would -- what is your expectation as far as -- you've mentioned a couple of times that Dr. Paidipalli should have ensured that Nurse Kish was trained or something to that effect. Do you train the PACU nurses?

A I don't train my nurses, but I know my strengths and weaknesses in my nurses. So in certain areas where we anesthetize patients, they go to a recovery room that has nurses that are less experienced taking care of certain types of patients.

And as the anesthesiologist supervising the patient's care, it's my responsibility to know the strengths and weaknesses of my team members. And, you know, that's part of my job, and until I assess each member of the team, I have a fiduciary duty to that patient to ensure that they are protected.

And sometimes that means a little bit more work for me, but that's what I do, and that's what

I think most physicians do in similar situations.

Q Do you have any reason to believe that the physicians in this case did not think that Nurse Kish was a well-trained nurse?

A The fact that Dr. Paidipalli didn't go back and re-assess the patient for ninety minutes and talk with the patient would make me believe that he did not appropriately assess that.

Q Why so?

A Because any PACU nurse -- I would have checked a patient before ninety minutes of being in the recovery room, and especially Brett. I would have expected that a prudent physician would have assessed him much quicker than that.

And other than that, I don't know if Nurse Kish has a history of being on Facebook or being on the computer, but -- and not paying attention to the patient. I think that's irrespective -- but it's his responsibility to know the strengths and weaknesses of his team members.

Q All right. I asked you this question before and you --

A Yes, sir.

Q -- didn't necessarily answer it. Are you saying that Dr. Paidipalli was the captain of the

ship here, that he had a duty to ensure that everyone else was doing their job?

A He had an obligation to ensure that the patient is cared for, and he supervises their care. And that means that he appropriately -- in order to appropriately supervise, you don't do their job for them, but you make sure that in leaving a patient in the care of another provider, a nurse or a CRNA or a respiratory therapist, that that patient is not being abandoned, in essence, that that provider has the adequate knowledge, abilities, to care for that patient.

And so, yes, he has that responsibility. The "captain of the ship" analogy -- if you want to use that, that's your own words. It's not mine. There's multiple physicians involved in the care of that patient or any patient in an operating room. And an anesthesiologist has certain responsibilities. The surgeon, even though the patient is in the PACU, has certain responsibilities to care for the patient.

That's a collaborative effort between the two physicians, between the surgeon and the anesthesiologist that shared responsibility for that airway. They both had a duty to make certain that the patient was adequately cared for in the recovery room.

You can use whatever analogy you wish to, and if your analogy is "captain of the ship," and that helps you understand it better, then so be it. It's much more complex than that. And some people would not choose to describe it as such.

Q If Nurse Kish felt she was inadequate to take care of this patient, did she have a duty to notify the physicians of that?

A Yeah.

Q Number 10. I think we've kind of talked through all of this, but if you'd go ahead --

A Yes, sir.

Q -- and read No. 10.

A As read, "Neither physician adequately observed the patient in the PACU so as to be able to exercise any judgment whatsoever. The patient was abandoned. It does not appear that either physician advised the PACU nursing staff of the risks of the particular patient.

"The anesthesiologist did not ensure that there was an adequate transfer of care, information, nor remain with the patient as long as medically necessary, nor ensured that the patient was discharged from the PACU unit in accordance with proper anesthesia policies. The ENT surgeon did no better."

I may not check on someone in ten minutes if they are an otherwise healthy patient who is getting a bunion removed and they had an uneventful case, but based upon the data that's present and the Anesthesia Care Record present, any prudent anesthesiologist would have checked on him in a more reasonable period of time.

Q Do you know Dr. Ira Landsman?

A I do not.

Q Have you read his report in this case?

A I have.

Q And have you read Dr. Martin's report?

A He is an anesthesiologist at Arkansas; is that right?

Q Uh-huh [affirmative].

A Yes, I have.

Q And did it surprise you that others disagree with your opinions?

A Does it surprise me? It surprises me that anyone would look at the chart and come up with a different opinion than what I saw. I guess everybody has their own motivations in why they might say something and maybe don't look through the whole chart, I guess.

I don't know if they did or not and

And what I refer to is, basically, guidelines for the care of -- the anesthesiology.

Q What do you mean by the patient was abandoned?

A So patient abandonment is defined, I know, by the ASA by basically -- there's a -- you have a duty to transfer the care to an appropriately trained patient -- I mean provider, such as a -- it can be a nurse, but that the transfer of data and information and relevant facts pertaining to that patient are also transferred. So by not doing so, that's abandonment.

You know, if I just drop a patient off in the recovery room and, even though there's nurses there, I don't convey to them the care that I had given them, that's abandonment.

That is not -- and there's no evidence to me, that I saw, that Nurse Kish was fully aware of the situation; specifically the CO2 being high, in the operating room, and the patient was probably in a state of anesthetic when he arrived in the PACU.

And then further, Dr. Paidipalli for ninety minutes, again, did not check on the patient as a reasonably prudent anesthesiologist would have done in that situation for Brett Lovelace, based upon his medical condition.

whether they saw every piece of data that I saw. I don't know either one of these physicians personally, but a Dr. Landsman used to work here, but he no longer works here, I don't think.

Q Do you know anything about Dr. Landsman?

A Oh, I ...

Q Other than he used to work here?

A Yeah, that's it.

Q He was in the Division of Pediatric Anesthesiologists here?

A Yeah, I saw something, some -- something referred to about his C.V., but I don't remember seeing his C.V.

Q Do you agree that there's no cookbook, per se, that a physician can go to to learn how to practice medicine?

A Absolutely not.

MR. LEDBETTER: Objection to form.

BY MR. GILMER:

Q Do you agree that doctors are called upon every day to make judgments?

A Absolutely.

Q Is an error in judgment always negligence?

A It is not.

Q Do you agree that bad results can happen and often do even when the standard of care is adhered to?
A I do agree to that.
Q Has that ever happened to you?
A I can't think of a specific course.
Q Have you ever had a bad outcome?
A I never had a death.
Q Ever had an unexpected PACU course?
A Yeah -- yes. I'm sorry.
Q Have you ever deviated from the standard of care?
A Have I ever deviated from the standard of care? I don't remember a specific case where I deviated from the standard of care.
Q I'm almost finished with my questions, if you'll give me just a couple of minutes.
. Do you have any criticisms of Brett's parents in this situation, being in the PACU with the child and seeing what was going on? Do you have any criticisms with them at all?
A I've never been in their position, so it's hard to say that.
Q Have we discussed all of your opinions concerning Dr. Paidipalli and the anesthesia care in

this case?
A We've reviewed what I've written down and submitted here. If there's anything else you want to ask about specifically, I'll be happy to answer.
Q Well, do you have any other opinions that are not contained in this disclosure? Because this disclosure is supposed to contain all of the opinions that you have in the case.
MR. LEDBETTER: He gave you a document earlier, gave you have some pages earlier. I don't know what their role is, but -- do you want to ask him about that, or is that --
MR. GILMER: Well, the ...
MR. LEDBETTER: It's just a tech -- technical thing.
MR. GILMER: Sure.
MR. LEDBETTER: That's all. I don't want to make you ask him that.
MR. GILMER: I think that I've got what I needed to out of this, and so ...
BY MR. GILMER:
Q Will you agree to update any opinions that you develop concerning --
A Yeah.
Q -- Dr. Paidipalli?

A Yes, sir.
Q And Mr. Johnson has some questions about -- I know I have not gone through everything about Dr. Clemons, but Mr. Johnson will ask you about those. So --
A Okay.
Q -- what I'm -- what I am concerned about is making sure that we have discussed all of your opinions about the anesthesia care in the case.
A As far as I can reasonably ascertain. Based upon our discussion right now, we have discussed everything, yes, sir.
Q All right. Thank you.
A Yes, sir.
MR. LEDBETTER: I may need to take a momentary break. How long do you think you'll be?
MR. JOHNSON: I don't know, thirty, forty-five minutes.
MR. LEDBETTER: Okay. Do you mind?
MR. JOHNSON: No, no.
VIDEOGRAPHER: We're going off the record. The time is 4:37.
(Recess taken.)
VIDEOGRAPHER: We're back on the record. The time is 4:44.

EXAMINATION
BY MR. JOHNSON:
Q Now, Dr. Kennedy, what hospitals do you have privileges at?
A Currently, Vanderbilt University Medical Center.
Q All right. And that's an adult hospital, correct?
A That's an adult hospital. We do take care of some children here, but usually that's for burns.
Q Okay. But you don't, do you?
A I do not attend in the Burn ICU, no, sir.
Q All right. And your privileges -- when you apply for privileges, you have to designate what type of medical -- either specialties or problems that you are applying for, correct?
A Yes, sir.
Q And your privileges are limited at the Vanderbilt Hospital to anesthesia, correct?
A To anesthesia and critical care. I have additional --
Q Well, okay.
A -- privileges as an intensivist over a

general anesthesiologist.

Q Okay, but with those limitations, that's what you are qualified to do at the Vanderbilt Hospital?

A Yes, sir.

Q And it doesn't include tonsillectomies or adenoidectomies, correct?

A Yes, sir.

Q It does not include any kind of surgery, does it?

A It involves any type of emergency procedure, including thoracostomy tubes which would be a semi-surgical procedure or ECMO initiation, but no, it does not include any type of tonsilar surgery.

Q All right. Do you know Dr. Werkhaven?

A No, sir.

Q Who is the chairman of your division?

A The chairman of my division?

Q Yeah.

A Of Anesthesia Critical Care, would be Dr. Pratik Pandha- -- Pandharipande.

Q All right.

A I'll get this --

Q You had trouble with it, and so would I.

A Yeah.

Q Spell his last name.

A Uh ...

Q You've got to look it up?

A I've got to look at it. It's P-A-N -- I know it when I see it -- P-A-N-D-H-A-R-I-P-A-N-D-E.

Q Y'all are close friends to the extent that you don't even know how to pronounce his last name?

A Yeah. And we call him Pratik.

Q Okay.

A Even the residents do, because he knows it's hard to pronounce his name.

Q Okay.

A He's more laid back.

Q We talked about your notes or whatever you wrote out and you've left them at home. I asked for those in addition to Dr. Paidipalli. I don't know what Mr. Ledbetter's position is, but I asked you to produce those.

A Okay.

Q Can you do that?

MR. LEDBETTER: I objected to that and filed an objection to it weeks ago. And I've asked that the witness not making contracts with people to do work.

BY MR. JOHNSON:

Q Well, the notice requires you or asks you to bring with you today any notes or things that you have, correct?

A I think the notice he showed me today does, yes, sir.

Q Yes.

MR. LEDBETTER: The notice was contrary to law, and I made an objection to that.

BY MR. JOHNSON:

Q And you did not bring anything with you, did you?

A I brought that one piece of paper I gave you guys.

Q Okay. That's all, though?

A Yes, sir.

Q Okay. With regard to a patient who is going to be put to sleep -- that's a lay term for what you are, as an anesthesiologist.

All right. With regard to a patient who is going to be put to sleep, the anesthesia performs a pre-op examination, correct?

A The anesthesiologist does perform a pre-op evaluation, yes, sir.

Q Okay. And that would include history

and whatever examination or whatever labs or whatever the anesthesiologist needs, correct?

A Yes, sir.

Q And that was done in this case, was it not?

A As best as I can tell, a reasonable evaluation was done, but again, I cannot reasonably interpret Dr. Paidipalli's limited notes.

Q Okay. But that would have been at least something that he would have been charged with doing, correct?

A Yes, sir.

Q Okay. And then the anesthesiologist puts the patient to sleep?

A Yes, sir.

Q The anesthesiologist or the CRNA monitors breathing during the procedure?

A He or she does, yes.

Q All right. Same with blood pressures?

A Yes.

Q What else does the anesthesia monitor during the surgery?

A The anesthesiologist or CRNA, either one who is in the room, will monitor their tidal volumes, their oxygen saturations, their respiratory rate, the

amount of fluid administered, the medications given, the patient's response to surgical stimulation.

I would also -- you know, my experience is that frequently the surgeon is aware of those things, too, because the monitors are clearly, usually, visible for most people in the room to see easily.

Q But the anesthesiologist or CRNA are charged with monitoring those things that you just mentioned, correct?

A Yes, sir, they are.

Q All right. And the anesthesia intubates the patient?

A An anesthesiologist or a CRNA would intubate the patient, yes, sir.

Q Okay. When I'm using the word "anesthesia," I'm broadening -- it's either an anesthesiologist or the CRNA, correct, that will intubate the patient?

A Yes, sir.

Q Okay.

A Anesthesia is probably more of a noun. I'm just -- I'm not trying to be picky, but it's -- I mean an anesthesiologist is --

Q I know. I'm not going to get into the grammar. I'm trying to get the deposition through.

A Yes, sir.

Q Do you mind just if we use "anesthesia" to include the anesthesia personnel?

A That's an original statement.

Q Is that a noun?

A Yes, sir.

Q Is that a noun?

A Yes, sir.

Q Is that okay for you?

A Yes, sir.

Q Okay. And so if we've got -- noun -- "anesthesia," that person intubates a patient before surgery, correct?

A Yes, sir.

Q And the anesthesia -- noun -- then monitors the intubation or the ventilation during the procedure, correct.

A Frequently, the anesthesiologist or the CRNA would intubate. There are occasions where an ENT surgeon might actually intubate --

Q Okay.

A -- a patient.

Q But in their -- usually, though, and in this case, it was anesthesia, correct?

A It was the anesthesiologist or the CRNA,

yes.

Q Okay. And then when the surgery is over, then the anesthesiologist, or the CRNA, first decides when to extubate the patient, correct?

A Usually, they do, yes, sir.

Q All right. And did they in this case?

A They did.

Q All right. And it's your criticism -- one of your criticisms is that they intubated this patient too soon?

A No, sir --

Q Is that correct?

MR. LEDBETTER: It's "extubate."

BY MR. JOHNSON:

Q I'm sorry -- extubated too soon?

A Yes, sir. They extubated too soon, yes, sir.

Q Okay. And you've told us that that caused the ultimate respiratory distress at the end?

A That was the beginning of the problems, and there are multiple issues that prevented that patient from being saved, yes, but that was the, you know -- I don't know if I would use the word, root cause, but it's probably the most -- you know, that was the beginning of the problems.

Q Okay. And was that the most important factor in what ultimately happened?

A I don't know. That would be conjecture on my part, but I would say that was the inciting event. Was Brett able to be saved if, you know, five minutes after walking in the PACU or rolling into the PACU, if Dr. Paidipalli would have came back and reassessed the patient? I don't know.

If your ENT surgeon would have done something when he stopped by to see the patient, would he have been saved? That would have been conjecture on my part.

Q Well -- but you sat here for three hours in giving us opinions and -- many of which are conjecture, in my opinion. Now, are you not in a position to say that the extubation too soon was the precipitating cause of what ultimately happened?

MR. LEDBETTER: I'm going to object as to form.

MR. JOHNSON: Okay. You've done it.

MR. LEDBETTER: Well --

MR. JOHNSON: You don't need to --

MR. LEDBETTER: It's a compound question.

MR. JOHNSON: No -- well, you don't need

to say it. Just object.
BY MR. JOHNSON:
Q All right. Go ahead.
A So could you restate your question, please?
Q Yeah. Are you -- you have given opinions for three hours --
A Yes, sir.
Q -- while we've been asking you questions. Now I ask you a question. You say, well, it's speculative.
All right. I want to know what your opinion is as to whether the extubation that was done too soon, according to you, was a primary cause in the ultimate outcome.
A It was one of the causes of the ultimate outcome.
Q All right.
A And Dr. -- the ENT surgeon not assessing the patient appropriately, nor doing anything about the fact that he noted the patient was in an inappropriate position was one of the issues, also.
Q Okay. Well, are there any other issues, or those -- just those two issues?
A The fact that the anesthesiologist

didn't come by. And if you look at the remainder of my statement, those are the issues.
Q Okay. But I'm asking -- I'm breaking it down. I'm asking -- and I use the word "primary." Was that a primary factor, the fact that this patient was extubated too soon?
MR. GILMER: I'm going to object to the form.
THE WITNESS: I'm not going to give a number because I think that would --
BY MR. JOHNSON:
Q I'm not asking you for a number. I said was that a primary factor in what ultimately happened?
A I've made my statement, all my statements of the contributing factors.
Q I'm asking you if that was a primary factor.
A I've answered --
Q Yes, no, or you don't know?
A I've answered. I've made my statement.
Q No, no. We're going to stop then if you're not going to answer. I get to ask the questions. You get to answer. All right?
Now, I asked you: Was that a primary factor that he was extubated too soon?

A That was one of the factors.
Q Okay. Was it a primary factor?
A That was one of the factors.
Q Was it a primary factor? Are you not going to answer that question or not?
A I've answered your questions.
Q You're not going to answer that?
A I've answered your questions.
Q No, you haven't. I said, was that a primary factor, in your opinion?
MR. LEDBETTER: I'm going to object. It's been asked and answered. You're wanting a specific answer and the use of a word, and I just object to that continued repetition.
MR. JOHNSON: Well, he's not answering.
BY MR. JOHNSON:
Q Sir, are you not going to answer that? Just say. If you're not going to answer it, that's fine.
A I've answered my -- your questions to the best of my ability, yes, sir.
Q So you're not able to say whether it was a primary factor or not; is that what you're saying?
A My statement is made. I've said what are the contributing factors to Brett's death, and that

is one of the factors.
Q Was that the initial initiating factor?
A That was the first and -- from a time line standpoint, yes.
Q Was it an important factor?
A Yes, sir, it was an important factor.
Q In the PACU, as you mentioned earlier, sometimes it's one-on-one; sometimes it's one nurse for two patients, correct?
A Yes, sir.
Q Is one-on-one, at least theoretically, better than one-on-two?
A Theoretically, yeah.
Q Okay. In this case, it was one-on-one, correct?
A Yes, sir.
Q And a PACU nurse is charged with the responsibility of monitoring a patient's airway?
A Agree.
Q As far as surgeons, are surgeons charged with the administration of what goes on in the PACU, or is that an anesthesia function?
A Usually, it is the anesthesiologist that is responsible in the ICU, but any physician, especially a surgeon who operated on a patient, would

be expected to act in a way that's appropriate for a given patient.

Q Okay. But as far as the responsibility, it's the anesthesiologist, correct?

A The anesthesiologist should have checked on the patient in the PACU, yes, sir.

Q Okay. And there's no requirement that a surgeon even go to the PACU, correct?

A No, there's not a requirement, but the fact that he actually showed up, actually saw the patient evaluated, is probably more concerning in that he didn't take the action, due to convenience or whatever reason. That would be, you know, conjecture on my part as to why he didn't do what a reasonable physician, any physician, would have done in the same situation.

Q And is it your position that the fact that the patient was prone -- that that was a situation that Dr. Clemons should have rectified?

A He made a comment about it. Yeah, he should have rectified it and he should have called the anesthesiologist at that point when he noticed that the patient was in a position that is not consistent with what his previous patients -- that he had cared for.

Q Well, but a patient who is prone with

his head turned to the side -- that's a good position for a post-tonsillectomy patient because they are not going to aspirate, are not as likely to aspirate on blood, correct?

A Probably, in an 86-kilo twelve-year-old -- probably not, no, sir.

Q Okay.

A And there was not clear evidence that the patient had his head to the side. There was some debate about whether or not he was face-down or had his head to the side.

Q Did you read Nurse Kish's deposition?

A There is one statement that she made at one point that said the patient's head was turned.

Q It was always turned to the side, correct?

A At one point, she said his face was in the mattress.

Q Did you not read where she said that it was turned to the side the whole time?

A I think there was a statement somewhere in there -- and I forget exactly where -- where there was something about the face being --

Q "Question: Was it to the side the entire time that he was in there?"

"Answer: It was, it was."

That's what she said, isn't it?

MR. LEDBETTER: I'm going to object. She said in paragraph 6 of her plea that he was on his face the whole time. So there's a conflict.

MR. JOHNSON: All right. All right. Do not make any speaking objections, please. If you're going to do that, then let's start --

MR. LEDBETTER: I made an objection --

MR. JOHNSON: Let's just stop. Then we'll come back.

MR. LEDBETTER: You can stop if you want to.

MR. JOHNSON: But I want you to stop.

MR. LEDBETTER: What you're doing is deceptive and unfair.

MR. JOHNSON: Well, you can redirect. You can redirect, if you want to, all right, but if you want to object, you say "objection." You don't make speeches like you're doing.

MR. LEDBETTER: I don't -- I'm free. I can state the basis for my objection. If I don't, it's not preserved.

MR. JOHNSON: No. It -- you didn't state a -- you made a speaking objection where you

wanted to comment on testimony or a document that we haven't even talked about.

MR. LEDBETTER: I'm sorry. You want to be deceptive, and I did make a comment.

MR. JOHNSON: I'm not -- it's not --

MR. LEDBETTER: Try not to be deceptive, and I won't have to make that kind of comment anymore.

MR. JOHNSON: Well, do you want to see what's in the -- what I just read? That was not deceptive.

MR. LEDBETTER: In Paragraph 6 of her plea --

MR. JOHNSON: I didn't read Paragraph 6 of her plea.

MR. LEDBETTER: You sure --

MR. JOHNSON: I read the deposition testimony.

MR. LEDBETTER: You sure did, and it's under oath.

BY MR. JOHNSON:

Q All right. Did you see where she said in her deposition that it was turned -- his head was turned to the side the whole time?

A I saw that, and also, I saw her plea where she actually stated that the face was face down,

too.
Q Okay. Then --
A We've lost the order --
Q But you're not --
A Sorry.
Q Yeah, but you're not saying that a patient has a compromised airway if they are lying with their face turned to the side, are you?
A Compromised diaphragm. So they can't take normal tidal volumes, especially a child of his size.
Q Okay. Well, are you saying then that this patient had a compromised airway for the ninety minutes that he is in the ICU -- I mean PACU.
A Compromised diaphragm. His ability to ventilate was not preserved, as evidenced by the fact that his CO2 was over 100.
Q Okay. And would Nurse Kish be expected to monitor that?
A Well, she wouldn't have a way to monitor directly his CO2, per se, as we discussed already.
Q But I'm talking about the airway. Isn't she charged with monitoring the airway?
A Yes, sir.
Q Okay. And so presumably she was

monitoring it, and if there had been a problem with that, then she should have called somebody or done something about it.
MR. LEDBETTER: Object to the form.
BY MR. JOHNSON:
Q Is that true?
A I'm sorry. Repeat one more time.
Q Is it your opinion that if she was monitoring the airway and there was a problem with the airway, then she should have done something about it or called someone to do something about it?
A I think that's an accurate statement, yes, sir.
Q You're not able to say -- between the time that you say he was extubated too soon and the time of the code, you're not able to say in that time frame when, let's say, the die was cast --
A Yeah, that would be --
Q -- and could not be resuscitated or salvaged; is that correct?
A That would be conjecture.
Q Is that correct?
A That is -- would be conjecture.
Q Okay. You can't put a time --
A No, sir, you cannot.

Q Okay.
A And it could have been before or after the ENT surgeon stopped by to see the patient, yes, sir.
Q It may have been too late by the time Dr. Clemons even saw the patient in the PACU, correct?
A That is not beyond the realm of possibilities, correct.
Q Okay. You, I think, have said this, but I'm going to put it in these terms. You're not qualified to give standard of care opinions as to the practice of otolaryngology?
A I'm not an ENT surgeon, no, sir.
Q Okay. Well, just say yes or no. You're not qualified to do that, are you?
A I'm not qualified to give what the standard of care for an ENT surgeon -- but I am qualified to say what the standard of care for a physician who sees a patient who's in an inappropriate position and has a compromised airway.
Q Okay. Are you saying that if ... if he had been lying on his back that this never would have happened?
A "If he was lying on his back, this would have ..." If he was lying in a position where he would

be assessed and he was assessed, as appropriate, this might not have happened, but to say that it never would have happened would be conjecture.
Q Okay. Well, but you're saying that it -- that he was lying prone, and you seem to complain about that, that that was not a good position, correct?
A I think that contributed to the situation, yes, sir.
Q Okay. I'm asking you, if he had been lying on his back, would this have happened?
A Usually -- like I said before, usually we don't keep them supine. Usually, we do lateral or the semi-lateral position.
Q Well, all right. We'll start with supine. If he were supine, would it have happened?
A Don't know. That would be conjecture.
Q All right. If he was lateral -- can you say that if he had been lateral, lying on his side, that this would not have happened?
A No, sir.
Q In your disclosure, it says, quote, I'm familiar with the applicable standards of care and issues in this case specifically regarding anesthesiology treatment and care, medical, surgical and post-surgical/PACU care." Is that your statement?

A Are you referring to -- was this the first page of my --
Q Uh-huh, yeah.
A At the bottom, sir?
Q Yeah, uh-huh.
A Yes, sir.
Q Who decided when to extubate this patient?
A The anesthesiologist, I presume. There's no clear documentation that he was present at the extubation.
Q Well, either the anesthesiologist --
A -- or the CRNA.
Q -- or the CRNA?
A Not the surgeon.
Q Right. And what is the criteria that you say was violated in this case by extubating this patient, you say, too soon?
A A -- sorry. Rephrase the question.
Q Yeah. What is the criteria that you're using to say that this patient was extubated too soon?
A As I've stated before, his tidal volumes were not adequate and he was hypercarbic, so he had inadequate ventilation.
So when we're looking to extubate a

patient, we look at -- you know, does he have reversal or no muscle relaxant, you know, for doing it awake, as they claim that they were doing. Is he adequately ventilating and oxygenating? Is he adequately following commands? Those would be part of that.
So the fact that he was clearly not adequately ventilating -- as the Anesthetic Care Record documents would show that he was not -- met the criteria, yes, sir.
Q When a patient is in the PACU, who decides when the patient can be discharged from the PACU?
A Usually, it's an anesthesiologist's decision. Frequently, though, the surgeons will weigh on to whether or not they go home or whether they, you know, stay in the hospital.
Q Okay. But the actual discharge decision, though, is a responsibility of the anesthesiologist, correct?
A Usually, it's made in -- it's a combined decision, but I'd say the weight goes towards the anesthesiologist, yes, sir.
Q Was this patient breathing during the ninety minutes in the PACU?
A It's charted that he was breathing in

the ...
Q And if he had an oximeter on the finger that was operating properly, that would, what, confirm that there is oxygenation?
A It would confirm that there was some oxygenation, but it has no -- it would not necessarily confirm adequate ventilation.
Q You mentioned that bleeding is probably the number one postoperative complication in a patient who has had a tonsillectomy or adenoidectomy, correct?
A Yes, sir.
Q And had that occurred, then that would have required the surgeon to be called in and pressed into service, correct?
A Yeah. And that could have been part of the reason, you know. Looking not from the retrospective scope, which we have the privilege of doing, but looking from the ante-scope -- you know, looking forward, you know, Brett could have been -- you know, with that blood pressure being low and everything else going on -- I mean he could have bled, and it could have went into his stomach, and you wouldn't have seen it.
Q Uh-huh.
A I think his initial blood gas after he

coded -- he had a lactate that was quite high, and the significant acidosis had -- a lot of it was respiratory, but there was some metabolic component --
Q Okay.
A -- and so that would be something, as an anesthesiologist, I would evaluate, and I would expect the surgeon to have that -- you know, since it's the most common.
Q Well, we don't have any evidence, though, that this patient had a postoperative bleeding?
A No, sir, we don't.
Q Is that right?
A That's right.
Q Okay. Do patients move when they are in the PACU?
A Yeah.
Q Can they move on their own?
A Yes, sir, should be able to.
Q Can patients who move breathe?
A Yes.
Q You've read Nurse Kish's deposition and you've seen the other documentation that refer to her treatment in this case, correct?
A Yes, sir.
Q You saw where she lost her license?

A Yes, sir.
Q She was terminated --
A Yes, sir.
Q -- from the hospital. Did you ascertain what occurred with regard to any problem with what Nurse Kish did or Le Boneur Hospital did?
A I'm sorry. Could you ...
Q Yeah. Do you acknowledge that what Nurse Kish did was a departure from the standard of care for a PACU nurse?
A Yeah, I would agree so, yes, sir.
Q Okay. And her employer was Le Boneur Hospital, as far as you know, wasn't it?
A As far as I know, yes.
Q Okay. Would they be responsible for her?
MR. LEDBETTER: Object. It's a legal opinion.
THE WITNESS: I presume, but that would be conjecture on my part.
BY MR. JOHNSON:
Q Well, but you said that the anesthesiologist is responsible, that you're responsible for the nurses or the team that works under you, correct?

A Yes, sir.
Q Okay. Would that not be applicable to Nurse Kish?
MR. LEDBETTER: Object as to form.
THE WITNESS: I'm trying to think of an appropriate way to answer your question. I'm not trying to be evasive. I'm just trying to answer your question that -- from an operational standpoint of a physician, regardless of who that nurse is paid for, who her paycheck comes from --
MR. JOHNSON: Uh-huh.
THE WITNESS: -- she still answers to the physician. And physicians are still charged -- and be it the ENT surgeon or the anesthesiologist or a proctologist who happens to come by, it's still a physician in the hospital and still has a certain authority over the patient -- and especially the ENT surgeon and the anesthesiologist.
BY MR. JOHNSON:
Q Well, but -- but in your hospital here, are the PACU nurses employees of you?
A They are employers of the hospital.
Q Okay. You can't say that if somebody had turned Brett over on his side that he would not have experienced what occurred in this case, can you?

A I can't say that.
Q This thing that you brought with you today, Smith's Anesthesia, states that agitation may be caused by numerous factors, including emergence delirium caused by anesthetic agents, pain, metabolic disturbances, neurologic disturbances, a behavioral response to sudden awakening in a strange environment, separation anxiety. So there are a whole lot of things that, at least, explain agitation when a patient is coming out of anesthesia, correct?
A There are. And usually the first things you assess for there are hypoxemia and hypercarbia because they are the most lethal of things.
Q Okay. Well, I'm just reading from what you handed us today.
A Yes, sir.
Q All right. Did I -- as far as you know, did I read that correctly?
A Yes, sir.
Q Okay. And there are multiple reasons why a patient is thrashing around or becomes agitated when waking up, correct?
A There are.
Q Did you see where this patient was agitated when he was being waked up or was waking up in

the operating room?
A As I remember, there were multiple referrals that he turned over on his face and moved around and was kind of -- knocked his probe off or something like that.
Q All right. He was belligerent or whatever you -- I don't know that "belligerent" is the right word --
A Probably not.
Q -- but he was fighting it, wasn't he?
A He was probably agitated and delirious, which the first thing, as an anesthesiologist, you're going to rule out is this --
Q Okay.
A -- hypoxemia and hypercarbia.
Q Okay. You were asked if anyone -- or you said that anyone in a hospital setting or a health care provider is capable of administering oxygen, correct?
A Any physician or nurse --
Q Okay.
A -- that was caring for a patient, yeah.
Q Yeah. Okay. Is a nurse capable of evaluating an airway?
A To a limited extent of evaluating if

it's -- if a patient is moving air, I would expect so. If it was actually done, yes.

Q Okay. And a PACU nurse would be -- that would be one of the things that a PACU nurse would be looking for, wouldn't it?

A Yes, sir.

Q You said that snoring can be an indication of an obstruction, but if someone is snoring, they are breathing, aren't they?

A You're breathing, but you may not be breathing adequately.

Q Okay. Well, but -- but there's air passing through the airway, correct --

A There --

Q -- for a patient that's snoring?

A By definition, yeah, but not necessarily adequate.

Q Okay. But this patient's parents -- or mother said that he was a snorer, correct?

A Yes.

Q And he had been snoring for -- it was more than just that presentation at the hospital. He was snoring when he was at home, right?

A Yes.

Q Okay.

A But he also didn't sleep knee/chest, and so as you stated earlier that if you're knee/chest, you're more likely for, actually, that tissue to be out of your way. So you would be less likely to snore. So if he was really snoring in that position, his airway was probably pretty obstructed.

Q Okay. Are you -- is it your opinion that he was still asleep when he was extubated?

A It's my opinion that he was likely still anesthetized enough to suppress his respiratory drive when he was extubated, yes, sir.

Q Okay. "Sleep," I guess, is a lay kind of term, but do you know what I mean by when I say "sleep" or --

A Well, differentiating those --

Q Was he still anesthetized to the point that he wasn't awake?

A He was anesthetized to the point where he wasn't adequately ventilating. And the subtleties of that are very important. So he might have moved around.

Q Uh-huh.

A He might have coughed. He might have lifted his head. He might have moved his arm, even purposefully.

Q Uh-huh.

A But that's not adequately awake.

Q Okay. Do you know that Nurse Kish has taken responsibility for what happened to Brett?

MR. LEDBETTER: Object as to form.

THE WITNESS: I'm aware of her plea and her losing her license.

BY MR. JOHNSON:

Q Okay. And didn't -- kept you from reading her deposition and seeing the other documentation in connection with losing her license, that she was taking responsibility for this?

MR. LEDBETTER: Object as to legal opinion being asked.

THE WITNESS: I think she was taking responsibility for not assessing the patient.

MR. JOHNSON: Okay. That all I have. Thank you.

MR. LEDBETTER: I just have a few questions.

VIDEOGRAPHER: Do you want to change tapes?

MR. LEDBETTER: No.

EXAMINATION

BY MR. LEDBETTER:

Q You have had your opinion admitted as an exhibit to the deposition. And I just want to ask you a couple of questions.

Are the opinions that you've expressed in your expert witness report relative to the physician and the oxygen supplementation and the extubation and the deviation of the positions still your opinion in this case, to a reasonable degree of medical certainty?

A That's my medical opinion.

Q Okay. And with respect to any questions where you were asked to speculate or engage in guess or conjecture, that's not what you did in your report; do you agree?

A No, I based it upon the available data that we had in the data points.

MR. LEDBETTER: Okay. That's all I have.

MR. GILMER: No follow-up.

VIDEOGRAPHER: That's the end of --

MR. GILMER: Don't walk off with that.

VIDEOGRAPHER: That's the end of the deposition. Is everybody done?

MR. GILMER: Yes, sir.

VIDEOGRAPHER: That's the end of the deposition and Disc No. 2. The time is 5:20.

(Deposition concluded at 5:20 p.m.)

STATE OF _____)
)
COUNTY OF _____)

I, the undersigned, declare under penalty of perjury that I have read the foregoing transcript, and I have made any corrections, additions, or deletions that I was desirous of making; that the foregoing is a true and correct transcript of my testimony contained therein.

EXECUTED this ____ day of _____, _____, at _____, _____.
(City) (State)

_____
JASON D. KENNEDY, M.D.

Subscribed and sworn to before me this ____ day of _____, _____.

Notary Public in and for said County and State

REPORTER'S CERTIFICATE

I, IVA L. TALLEY, LCR 336, Court Reporter in the State of Tennessee, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth.

That the statements made were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

I further certify that I am not a relative or employee of any attorney of the parties, nor financially interested in the action.

I declare under penalty of perjury under the laws of Tennessee that the foregoing is true and correct.

Dated this 7th day of July, 2014.

_____
Iva L. Talley, Court Reporter and
Notary Public at Large
Commission Expires: 7-21-16

Curriculum Vitae

Name: Jason D. Kennedy
Work Email: jason.d.kennedy@Vanderbilt.Edu

Education

08/1999 - 06/2003	M.D. in Medicine from University of Alabama School of Medicine, Birmingham, AL

Training

1992 - 1999	B.A. from UAB, Birmingham Alabama
07/2003 - 06/2004	Internship from Carraway Methodist Medical Center, Birmingham, AL
07/2004 - 06/2007	Residency in Anesthesiology from University of Alabama at Birmingham Medical Center, Birmingham, AL
07/2008 - 07/2009	Fellowship in Critical Care Anesthesiology from Emory University Medical Center, Atlanta, GA
07/2009 - 07/2010	Fellowship in Cardio-thoracic Anesthesiology from Emory University Medical Center, Atlanta, GA

Licensure and Certification

N/A	American Board of Anesthesiology, Diplomat of the ABA of Not Specified
N/A	American board of anesthesiology, Speciality certification in Critical Care medicine of Not Specified
2010 - 06/2020	American Board of Echocardiography, Special Competence in Advanced Perioperative Transesophageal Echocardiography (2010-00022268)
06/2010 - 06/2014	Tennessee medical license, Medical License of Tennessee (46094)

Academic Appointments

07/2008 - 07/2009	Instructor in Anesthesiology, Department of Anesthesiology, University of Alabama Birmingham-UAB (Birmingham, Alabama)
07/2010 - Present	Assistant Professor of Clinical Anesthesiology, Vanderbilt University (Nashville, Tennessee)

Professional Organizations

American Society Of Anesthesiologist
Society of Cardiovascular Anesthesiologist

Professional Activities

Intramural

10/10 - Present	Therapeutic hypothermia, Medicine, Intensive care represeative to this group, Physician represenative to this group alongwith Dr. Wagner
02/2011 - Present	Pharmacy and therapeutics, Pharmacology, represent intrest of the Department and the hospital to the P and T commitee. Full voting member., Anesthesiology represenative
01/2012 - Present	ICU Ultrasound, Anesthesiology, Developing standardized ultrasound curriculum for Intensive Care Fellows and Anesthesiology Residents

Teaching Activities

N/A	Hemodynamic Echo monitoring: Assesment of LV and RV function and clinical applicability, Simulation center
05/2010 - Present	Lung Isolation in Thoracic Surgery, Instructor
08/2010 - 2011	Perioperative managment of Aortic Dissections, Lecture and Group discussion, Fellows lecture room
08/2010 - 07/2011	Postoperative managment of Cardiac surgery patients, lecture and group discussion, Fellows confrence room
09/2010 - Present	Echo in the ICU
10/2010 - Present	Neuroprotection and Cardiac Surgery
11/2010 - Present	Modes of Ventilation in the ICU and OR
12/2010 - Present	ICU for Cardiac Surgery
02/2011 - 02/2011	Vasoplegia in the Cardiac operating Rooms, Lecture and group discussion
04/2011 - Present	ICU and Cardiac Surgery
05/2011 - Present	ICU and Cardiac Surgery
10/2011 - Present	ICU for Cardiac Surgery
12/2011 - Present	Lung Isolation in Thoracic Surgery
02/2012 - Present	Pulmonary Hypertension
02/2012 - Present	Vasoplegia in the OR and ICU
02/2012 - 02/2013	Vasoplegia in Cardiac surgery, Lecturer, Monthly lecture on Vasoplegia in CT surgery and Critical Care
09/2012 - Present	Echo Bootcamp for ICU fellows, Course Director, Vanderbilt University, Developed a two day course to acclimate and familirize fellows in the perioperative use of echocardiography and ultrasound for criticaly ill patients.
12/2012 - 2013	Right Heart Dysfunction in the Operating Room, Lecturer, Lectured for one hour on Right heart failure in the perioperative enviorment
01/2013 - 01/2013	Medical Student UImmersion COurse: Managment of valvular disorders, Lecturer, Vanderbilt University, Taught A small group case based one hour lecture on valvular abnormalities

Other Significant Activities

02/2012	Blood conservation in the ICU: Developed evidence based approach to Factor VIIa utilization and product managment .This has led to the dramatic reduction in the utilization of Factor VIIa with a costs savings of about half a million dollars in factor VIIa alone.
07/2012	Course director for Critical Care fellows rotation in Ultrasound/echo: Developed syllabus, course and lecture series for ICU fellows to become profecient in the use of Cardiac, thoracic and occular ultrasound.
11/2012	Extra-Corpereal Life Support Course : Veno-venous ECMO Course for adult Respitory failure
01/2013	Medical director of Clinical Perfusion- Vanderbilt University: Clinicl Director of Perfusion- Act as a liason for perfusionist and help to develop protocls for ECMO and transfusion services for VHVI

Honors / Awards

2003	Alpha Omega Alpha Honor Society
2004	Top Ten Teacher of the Year Award, Department of Anesthesiology UAB

Publications

Non-Peer Reviewed Publications

Abstracts

1. Costello W, Billings F, Bick J, Kennedy J, Wagner C. Transesophageal Echocardiography as a Hemodynamic Monitor in Post Operative Cardiac Surgery Patients. 2011 Oct.

Research Articles

1. **Kennedy JD, Sweeney TA, Roberts D, O'Connor RE. Effectiveness of a medical priority dispatch protocol for abdominal pain. 2003 Jan;89-93. PMID: 12540150.**

Book Chapters

1. **Wagner, Ashby, Kennedy. Anesthesiology: A comprehensive Review for the Written Boards and Recertification Edited by Kai Matthes, Richard Urman, and Jesse Ehrenfeld . 2012 Nov;Chapter 20.**

Presentations

Invited Presentation - Regional

1. **Tennessee perfusionist society. Nashville, Tennessee. 2011 Sep 24; Colloids vs. Crystaloids in Cardiac surgery.**

Internal Grand Rounds

1. **Grand Rounds Department of Anesthesiology. Nashville, Tennessee. 2013 Feb 1; Perioperative managment of Right Ventricular failure.**

Presentations at Scientific Meetings

1. **Costello, Bick, Wagner, Billings. ASA-SOCCA. American Society of Anesthesiologist; Chicago, Illinois. 2011 Oct; Transesophageal Echocardiography as a Monitor in Post Operative Cardiac Surgery Patients.**

In the Matter Of:

DANIEL LOVELACE and HELEN LOVELACE Vs.

PEDIATRIC ANESTHESIOLOGISTS

ROBERT MARSCH

June 09, 2014

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riverside
REPORTING

22 North Second Street/Suite 303, Memphis, TN, 38103 (901) 527-1100

Q. Well, other than the fact that, that you understand that he was being home schooled, do you know anything else about his grades or educational accomplishments?
A. Not specifically. No.
Q. Why did you ask for that information then?
A. Well, for instance, if his grades were such that it was, let's say he was seventeen years old, had one, only one additional year of high school, he was in college preparatory classes, he was getting all A's and B's, then I would probably make sure at least that I included the calculation for a bachelors degree. Or sometimes, I mean, you could even make perhaps a justification if he had a specific career set out. You could make a justification for calculating an economic loss based on a specific career aspiration. So I typically will ask for that information. It doesn't mean I always get it, but I'll often ask for it.
Q. Well, in this case, you didn't get it, did you?

A. No.
Q. And so you didn't factor in his mental or educational accomplishments, or lack thereof. Is that a fair statement?
A. That's correct. I treated him as the average statistical individual and provided earnings for a range of different educational attainments.
Q. In a broad sense, what are the, what are these documents that are attached to the e-mail that I just referenced?
A. Those are work papers. They're entitled age earnings. They are a set of documents for different levels of educational attainment that take statistical data on earnings by five year intervals and enable me to compute what the earnings would be at different ages.
Q. All right. I believe that what you handed me, it's says preliminary draft dated 5/14. Is this your most up-to-date report?
A. It is.
Q. Okay. And then there's a stack of documents that has some handwritten information on the front. Is that yours?

assumptions will be, would be applicable in this case, do you?
A. I'm not going to second guess the jurors' decision with regard to where in that range of earnings it would be appropriate to put Brett.
Q. You could have made a fourth category -- well, at least another calculation based on this statistical information involving a white male who does not complete high school, couldn't you?
A. I could have. On the other hand, he is home schooled. And so the statistics available for those who are home schooled are not readily available. In other words, I don't have age earnings data for home schooled children. I do know that home schooled kids have a somewhat higher likelihood of attending college than a high school kid. But I don't have age earnings data for home schooled children so I have not used it.
Q. So the same source that you used for high school graduate, some college, and college graduate, it doesn't have that same information regarding someone who has not

completed high school?
A. Well, it has high school dropouts. But I don't know how you become a home schooled dropout. Assume that home schooled kids, they, they take tests which gives them some sort of certificate for essentially having completed high school. But I don't know that they are what I would call a high school graduate.
Q. Well --
A. So I don't know what, you know, a home schooled dropout would be. And I'm not sure at all a home school dropout would be the same set of earnings as that for a, you know, high school drop out.
Q. Well, if you have a GED, doesn't that at least tell someone that that person has the equivalent of a high school education?
A. Yes. Some of those statistics combine high school and GED educational attainments together. That's correct.
Q. Okay. But if someone drops out, whether they're dropping out from home school or dropping out from formal school, that's a high

school dropout, isn't it?

A. I don't know that I would consider that. I don't know -- you know, when you talk about ninth grade and tenth grade, I don't know where that comes within the home school side of things. I'm simply not an expert on home school, and there's not a whole lot of statistics with regard to the educational attainment of those who are home schooled that I feel comfortable relying on it.

Moreover, if you look at the statistics for high school, you're talking about 70 percent. And you can compute them based on the data that I gave you. But you're looking at -- well, let's be specific.

If you look at those with a high school education -- excuse me. Look at those, I'm sorry, with a high school, ninth to twelfth non-graduate. Out of 54 million people, there's only 2.298 that have ninth to twelfth non-graduate. And another 487,000 that have less than ninth grade.

So the numbers that you're talking about, while you could have included a range

statistically, not only do I not have data for home school, the statistical number of those folks that don't graduate from high school is insignificant compared to the other ranges for which I've provided data.

Q. All right. Do you think that it would be advantageous, from a potential earnings category, that Brett failed kindergarten, was diagnosed with a learning disability, by the time he was in the sixth grade he could only read on a second grade level? Do you think that that says a lot about his potential earning --

MR. LEDBETTER: Object as to form. You can answer.

THE WITNESS: I don't have an opinion on that. That requires the expertise from a medical perspective or a vocational expert perspective, and I'm not trained in either fields.

Q. (BY MR. JOHNSON:) Well, you're using it in part of your calculations there, a high school graduate; correct?

A. Correct.

Q. Okay. If you can't read but on a second grade level, you're not going to be a high school graduate, are you?
A. Well, it depends on what age you're talking about and how long you have to get through high school. If you're talking about someone who was in grade school or even in ninth grade, they may well improve their reading. And in fact, I would have to say at the University of Arkansas, we have folks that start college whose reading, they had to go through remedial reading just to survive in college at Fayetteville. And so I don't think that's determinative of how far one would get in their educational attainment.
Q. It's not a good sign though, is it?
A. Well, again, you're beyond my --
Q. Would you answer me, sir, with you answer. It's not a good sign, is it, if you can't read but on a second grade?
MR. LEDBETTER: Object as to the --
THE WITNESS: At what age? If you're saying at age, at sixth grade, if you can't read --

Q. (BY MR. JOHNSON:) Yes.
A. -- at seventh grade level.
Q. Yes.
A. No. I would say if you, if your reading is slow, that's not a good sign. Whether it means a difference in your earnings or not, no. I don't have an opinion.
Q. If you wanted to, could you prepare a fourth column on people who have not graduated from high school?
A. Yes. You could look at the same data that I looked at and calculate the age earnings data for a ninth to twelfth grade, or a non-ninth grade graduate as to -- as I said, the statistical likelihood of that is not great, but you certainly can calculate it.
Q. All right. And in round numbers, the overall earning capacity of someone in that category, one who has not graduated from high school, is what, in the range of 25 percent less than a high school graduate?
A. Average earnings of a graduate, including GED, is 42,157. High school, ninth to twelfth is 26,833. So 25 percent less. Actually, it

shows less than ninth grade as being an average of 33,659, even greater than that with a ninth to twelfth grade non-grad. But would it be less? Yes. I haven't calculated whether it would be 25 percent or not, but that may be close.

Q. In round numbers, that's good enough, isn't it?

A. That may be close. I would like to calculate it, but I am -- that may be correct.

Q. Well, you said 42,000 versus?

A. 28. Well, if you took the average of them, you would be looking at the average of 33 and 26. So I would say 30, 42 to 30, that's 12 divided by 42. Yeah. It would be 25 percent.

Q. Okay. I'm not an economist, but I did figure that up. Will you accept that?

A. Yes.

Q. Okay. Thank you. Now, in making your calculations, you intended to replace what Brett might have earned in his lifetime; correct?

A. I didn't intend to replace. I simply